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ABSTRACT

The proceedings of the 1976 Orthopsychiatric Workshop on Deafness contains 33 papers on mental health for the deaf. Papers address the following five major topics (sample subtopics in parentheses): current status of mental health services for the deaf (hospital, clinic, and school based programs); federal perspectives (the impact of P. L. 94-142, the Education for All Handicapped Children Act); mental health needs of the deaf (needs of deaf adults, deaf women, and parents of deaf children); assessment, treatment, and research (psychological assessment and preventive mental health services); and the challenge of the future (responses from the National Institute of Mental Health, Rehabilitation Services Administration, and Bureau of Education for the Handicapped). (CL)

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Mental Health In Deafness

Experimental Issue No. 1

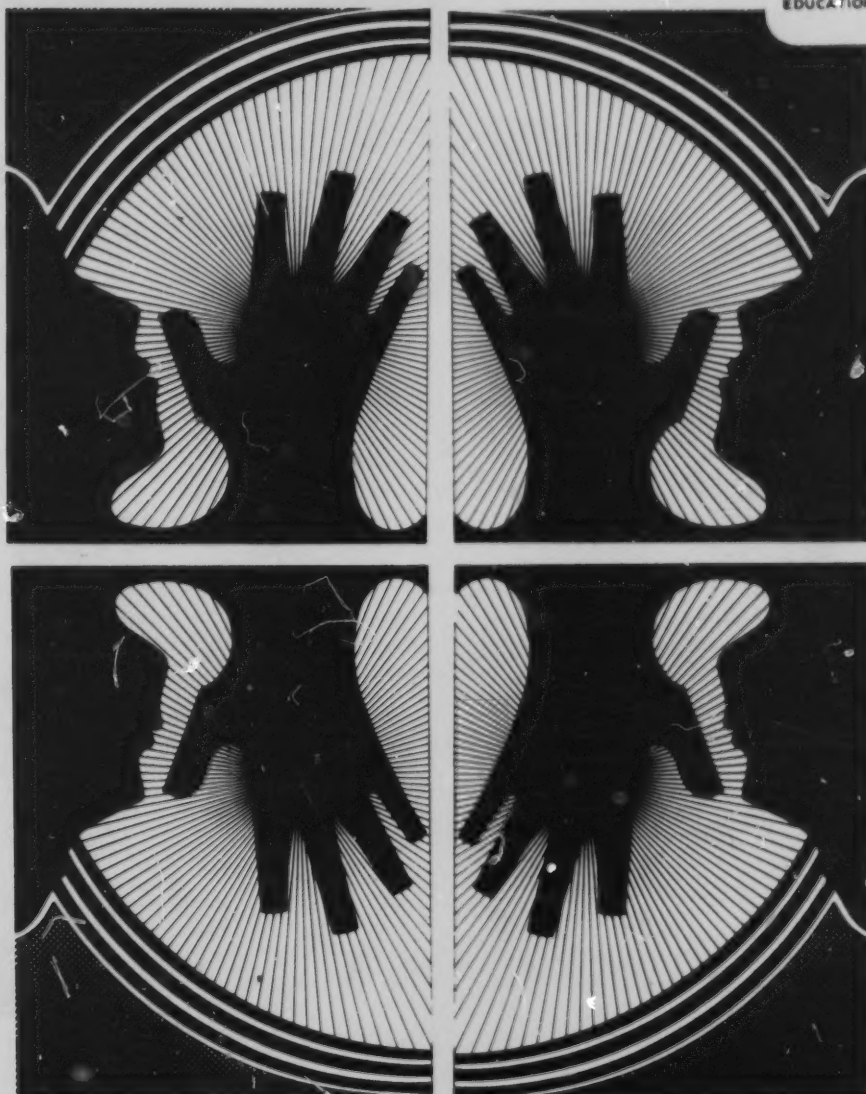
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The Future of Mental Health Services for Deaf People
Proceedings of the First Orthopsychiatric Workshop on Deafness



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(Continued on inside back cover)

MENTAL HEALTH IN DEAFNESS

A Journal of Saint Elizabeths Hospital
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Orthopsychiatric Workshop Proceedings

Raymond J. Trybus, Ph.D.

Mental Health in Deafness is an experimental publication of Saint Elizabeths Hospital; National Institute of Mental Health; Alcohol, Drug Abuse and Mental Health Administration. A limited number of copies of the experimental issues of this journal are available without cost to professionals in the field of mental health and deafness. To subscribe, write to Editor, *Mental Health in Deafness*, Saint Elizabeths Hospital, Washington, D.C. 20032. Material contained in this journal, including viewpoints expressed by Saint Elizabeths Hospital staff members, does not necessarily reflect the opinion, official policy, or position of Saint Elizabeths Hospital or the National Institute of Mental Health.

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Introduction

I am pleased to salute the appearance of a new professional journal in a specialized field: *Mental Health in Deafness*. At the same time, I wish to congratulate two persons of outstanding competence and compassion who originated—and carried to completion—the concept of the journal. They are Dr. Luther D. Robinson, Associate Superintendent for Psychiatry at Saint Elizabeths Hospital in Washington, D.C., who will be Editor-in-Chief of the journal, and Dr. Thomas J. Goulder, now director of a newly established community mental health center for the deaf people at the Massachusetts Mental Health Center in Boston, who advanced the idea for the publication while on the staff of Saint Elizabeths.

The journal will disseminate and exchange information on mental health activities for deaf people, stimulate the development of services to them in all parts of the Nation, encourage the training of mental health workers for the deaf, and promote research in this field. This outreach to the doubly handicapped is most welcome.

We do know that of the approximately half-million deaf persons in the United States, at least 40,000 require mental health services and only a small percentage are having their needs adequately met. This journal will help to remedy this situation.

Long ago, Dr. Sigmund Freud was asked to give a definition of mental health. His answer—seemingly simple but actually profound—was that it is “the ability to work and to love.” Everything we accomplish with and for the deaf is an act of love, and it is being extended to people who want and need to know how to work.

We anticipate that the appearance of *Mental Health in Deafness* will be a vital part of a giant step forward in services to the deaf.

Bertram S. Brown, M.D.
Director
National Institute of Mental Health

Welcome to a New Journal

Mental Health in Deafness is another major landmark to the foresight and leadership of Dr. Luther D. Robinson to provide improved mental health services for the deaf patients. Beginning in 1963, Dr. Robinson brought together a handful of deaf patients to form a therapeutic group. From this beginning eventually evolved a program that has treated nearly 200 patients in the District of Columbia and over half of the States. In 1977 the program, under the leadership of Dr. Doris Dickens, consists of 30 inpatients and 60 outpatients, and the Hospital's 5-year plan includes the development of an additional children's program in 1979.

As Dr. Robinson, members of his journal's editorial board, and Dr. Dickens have pointed out through the years, serving and studying the deaf who are mentally ill not only well serves the deaf but has the potential of helping us reflect on the care of the mentally ill in general.

Roger Peele, M.D.
Acting Superintendent
Saint Elizabeths Hospital

Mental Health in Deafness represents another major milestone toward improved mental health services for deaf people. Although tremendous strides have already been made in the availability of treatment programs, there is an obvious need for the sharing and dissemination of available information concerning the various accomplishments realized thus far as well as the unrealized goals which remain. Further, because of the scarcity of persons who are trained in both the areas of deafness and mental health, there is need for more information which interested persons could use as resource material for training purposes. Thus, *Mental Health in Deafness* should meet two very crucial needs — the need for the sharing of available information among those who are now working with persons who are both deaf and emotionally ill and the need for the sharing of this information with persons who are interested and motivated to become involved in a very specialized area of psychiatry for which there is a tremendous need.

Dr. Robinson and his colleagues who have worked so diligently should be highly commended for this most timely achievement.

Doris L. Dickens, M.D.
Director, Mental Health Program
for the Deaf
Saint Elizabeths Hospital

Editorial

This is the first issue of the journal, *Mental Health in Deafness*, published by Saint Elizabeths Hospital, Washington, D.C. The idea for this journal was considered for many years and was first presented to me by Dr. Thomas J. Goulder in 1968, shortly after he joined the staff of Saint Elizabeths' Mental Health Program for the Deaf on a full-time basis. Fleeting thoughts of such a journal continued over the years, and about 1 year ago the thoughts were formally presented to a group of representative staff members of the Mental Health Program for the Deaf. There was a consensus among those present that Saint Elizabeths should publish this journal, and it was agreed that opinions should be sought from others in the field of mental health and deafness. Fifteen resource people were contacted by letter and response was received from each, with the majority of the responses favoring publication of the journal.

The Hospital was then authorized through proper Federal channels to publish this journal. An editorial board consisting exclusively of members of the staff of Saint Elizabeths was appointed and an editorial advisory board consisting of experts in the field of Mental Health and Deafness outside of the staff of Saint Elizabeths was selected.

The purpose of this journal is to disseminate and exchange information on mental health activities for deaf people, stimulate the development of mental health services nationally and perhaps internationally, encourage the training of mental health workers, and promote research in this very important field.

For the current issue of the journal the editorial staff agreed to publish the proceedings of the Orthopsychiatric Workshop on Deafness sponsored by and held at Saint Elizabeths Hospital in Washington, D.C., May 18-19, 1976, and to use the services of Raymond J. Trybus, Ph.D., as guest editor.

The journal will be published on an irregular basis two to four times a year and it is my hope that the purpose of this journal will be well served.

Luther D. Robinson, M.D.
Editor-in-Chief

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THE FUTURE OF MENTAL HEALTH SERVICES FOR DEAF PEOPLE

**Proceedings
of the
Orthopsychiatric Workshop on Deafness**

**Saint Elizabeths Hospital
Mental Health Program for the Deaf
Washington, D.C.
May 18 and 19, 1976**

**Edited by
Raymond J. Trybus, Ph.D.**

Part I
OVERVIEW, INTRODUCTION,
AND BACKGROUND

THE FUTURE OF MENTAL HEALTH SERVICES FOR DEAF PEOPLE

Raymond J. Trybus, Ph.D.

Dr. Trybus is director of the Office of Demographic Studies, Gallaudet College, and consulting clinical psychologist to the Mental Health Program for the Deaf, Saint Elizabeths Hospital, Washington, D.C.

Conference proceedings are not often useful documents. In the printing trade they are sometimes referred to as "tombs" rather than "tomes," since their function often is more to give a decent burial to a past than to serve as midwife to a future.

But today the future of mental health services for deaf people looks bright, and this volume has a chance to be more midwife than mortician. The gestation period has been about right, too. The conference took place in May 1976, and while this is being written in the spring of 1977, President Carter has recently signed an executive order establishing a President's Commission on Mental Health, with First Lady Rosalynn Carter as honorary — and very interested — chairperson. The White House Conference on the Handicapped will convene shortly to perform its historic functions. With the opening of the 1977 fall school term the new "Education for All Handicapped Children Act" will go into effect amid widespread attention, praise, confusion, and hope. Implementing regulations to enforce section 504 of the Rehabilitation Amendments of 1973, the "civil rights" act for handicapped people, have at long last been signed, offering a promise of equality of access and opportunity never before available. The popular television news program "60 Minutes" has broadcast a story about Gallaudet College which has probably produced more general awareness of deafness, deaf people, and the college than any other event since President Lincoln signed legislation chartering the College in 1864. This "60 Minutes" segment has also been redistributed for use on inflight movie screens on coast-to-coast air flights. The Federal Communications Commission recently approved the use of television's "line 21" for the carrying of closed captions

which make available in written form, at the edge of the screen, the text of what is spoken on television programs, thus making it possible for the first time that television might become as accessible to the Nation's 13 million hearing-impaired citizens as it has been to the other 200 million citizens for more than 30 years.

It thus requires no great wisdom to see that there is now occurring in the United States a great confluence of forces, the eventual outcome of which may well be for citizens with disabilities the equivalent of the other great movements toward equality and liberation which have occurred in our Nation's history. Success is not guaranteed, as it never is; but clearly the times are right.

The times are right for a great leap forward in making helpful, dignified, high quality mental health services available to all our deaf people who need them and want them. But progress is only possible, not assured. We must seize the opportunity. Deaf people themselves must first of all lay claim to equal opportunity and insist that the best available be available to them as well. The friends of deaf people, their families, and the professionals in the mental health fields must respond to that claim and support it. The professionals will fulfill their moral and professional responsibility to help, not hurt, only if they abandon their claims to be masters and work instead at earning the right to serve.

There have been other conferences and other books, but the unique hope we have for this conference and its printed record is that it may serve as the rallying point for those of us — deaf people, their friends and families, and mental health professionals (including many of us who belong to more than one of these groups) — who are determined to take advantage of the climate

and events of our times to develop, expand, and improve mental health services for deaf people. The conference was the first time we all got together in person, learned each others' names and faces, and made collective plans. This book includes the first publication of descriptive information about the existing mental health programs for deaf people in schools, clinics, and hospitals and will be an important guide to available resources of people and services. Probably for the first time, the conference brought representatives of all the major units of the National Institute of Mental Health face to face with deaf people, with their need for mental health services, and with the "front-lines" professionals, both deaf and hearing, who provide the existing services.

Through this conference and this printed record, we now know that even under the most conservative estimate of the need, and the most liberal estimate of the available service, 85 percent of deaf people needing mental health services are *not* receiving them because they are not available. Less stringent estimates of need and availability suggest that only 1-2 percent of the need for services is being met. The challenge is equally great in services for children, adolescents, and adults.

Expansion of Services

The first need is for *more* services to be available to *more* people in many *more* locations. Achieving this easily stated objective will, of course, be anything but easy. Progress must be made on a variety of fronts. While this conference should bring the needs of deaf people to the attention of the personnel of the Federal agency most directly involved, the National Institute of Mental Health, their message was clear: Money is tight and will go to those who are most organized, visible, and coherent in their claims. We must become organized, visible, and coherent to the Federal agencies and to the Congress. But the Federal Government is not the only, or even the major, theater of action. NIMH, like other Federal agencies, views its funding as catalytic — that is, as providing assistance in research, in developing innovative programs, in getting services started where they are presently nonexistent or insufficient. NIMH does not see its role as providing major or continuing funding for the operational costs of established programs. These costs must be borne by State and local agencies. There, then, lie the

major struggles for funding of the operating costs of programs.

Deaf people, their friends, and the professionals who serve or wish to serve them must become organized, visible, and coherent not only on the Federal scene, but also in the legislatures and bureaus of the 50 States and the thousands of local communities where services are not now available. Some battle-scarred veterans of funding wars said at the conference that the critical need is for "line items" in the various State and local budgets; that is, for funds which are specifically earmarked or designated for the operation of mental health services for deaf people. Without this line item status, service programs for the deaf need to struggle yearly, or more often, for funding without the visibility to make the struggle for funds a public issue. An important factor in the attempt to gain funds is the demonstration of the need. Local community mental health centers might well be willing to request funds to establish services for deaf people *if* — and it is a critical *if* — they can document that deaf people have sought out services which the center was unable to provide. Without this clear demand for services from deaf people themselves, the agency is in a poor position to request funds. Without a demonstrable demand for the service, the request is easily seen as unnecessary and self-serving on the part of service agency staff.

So deaf people must overcome, and their friends and professional service-providers must assist them to overcome, their natural reluctance, at a time of personal or family need, to ask for assistance from hearing professionals when it is clear from the outset that the service is not really available. These considerations apply to the entire range of services, from inpatient psychiatric hospital care to crisis intervention services, to marriage counseling, to family and children's services. The situation is clearly not a case of "Ask and you shall receive," but it clearly is one of "If you don't ask you certainly won't receive." Key resources in each State or locality are chapters of the National Association of the Deaf or other associations of deaf people themselves; parents of deaf children and families of deaf people; the local chapter of the Registry of Interpreters for the Deaf; church groups which serve deaf congregations; the State Coordinator for the Deaf (SCD) — if there is one — within the State Department of Vocational Rehabilitation; State and local personnel from the educational programs for hearing impaired children. If another mental health program for

deaf people is located in a nearby city, personnel of that program would also be valuable resources. (A directory of the existing mental health services for deaf people appears elsewhere in this volume.) University-based research and training personnel in deafness-related programs might also be of assistance.

Training and Personnel

Along with concern for the simple existence of service programs for deaf people and funding sources for them comes concern for the personnel of such programs and for their training. As the discussions of the conference made clear, the personnel of mental health programs for deaf people need two broad sets of knowledge and skills in order to function effectively. On the one hand, each needs to be well trained in a mental health discipline: social work, nursing, psychology, psychodrama, psychiatry, or whatever. Deaf people deserve no less than the rest of us in having fully trained professionals to serve them. On the other hand, it is clear that knowledge about deafness and deaf people, and skill in dealing with deaf people, especially in the critical area of two-way communication, are of equally great importance to high-quality service.

Knowledge of deafness and deaf people is essential in order to avoid elementary but all too common errors. A deaf person animatedly trying to convey via pantomime what the professionals could not understand when it was signed is diagnosed as "agitated." The deaf person with an IQ test score of 125 is diagnosed as mentally deficient when he fails to understand the psychiatrist's questions, mouthed slowly and exaggeratedly, and when his spoken response is unintelligible to the professional. The deaf person with limited English language skill is diagnosed as schizophrenic on the basis of her ungrammatical written response to the professional's written (and idiomatically phrased) question. These examples are no exaggeration; all occurred during the last several months of the author's clinical practice, in the written reports accompanying referrals of deaf clients. They are errors made by otherwise knowledgeable and competent professionals, who simply lack knowledge of and familiarity with deaf people. The "internal norms" developed by professional workers over the course of years of practice are of special importance in work with deaf people, since so few sets of external or statistical norms are available.

Ability to engage in two-way communication with deaf clients is the major skill requirement which, in addition to the knowledge requirement, is necessary to the provision of services of acceptably high quality. While there may legitimately be differences of opinion on the relative merits of various modes of communication in the education of young deaf children, there can be no quarrel with the necessity of the professional worker's being able to communicate with the deaf client by whatever means the deaf client knows and prefers. This means, among other things, the need for the professional practitioner to learn American Sign Language in its several versions including, but definitely not limited to, such recent developments as Signed English and related systems. As one of the conference speakers noted, there are only three alternatives for the professional who is not able to communicate in sign language: learn sign language; use the second-best alternative — a sign language interpreter — while learning sign language; or limit one's clientele to people who can hear.

Training is needed at a variety of levels for a variety of personnel. At one level there is the need, somewhere in the United States, for doctoral and other graduate-level degree programs for those few persons who might wish to orient an entire career in mental health toward service to deaf people and their families. Sign language interpreters who are well trained and certified are in short supply generally, but interpreters who are also specifically trained and experienced in interpreting in the mental health setting are especially scarce and especially necessary for those many second-best situations in which a mental health professional fluent in sign language is simply not available. Training programs for such interpreters, with a heavy practicum emphasis, are much needed. There is a crying need for basic information about deafness and deaf people to be developed for incorporation into the preservice training programs of all the mental health professions, since a general awareness of the existence of deaf people and their special needs vis-a-vis mental health services is absolutely necessary if the general level of practice available to deaf people is ever to be improved.

Since we are all limited in our knowledge, however long we have been in practice, there is also a general need for inservice training or professional development activities for those persons professionally engaged, whether full time or part time, in providing direct services to deaf

people. Given the problems of small numbers widely dispersed, it would seem that a national, or at least regional, perspective would be necessary in planning for such continuing inservice training activities. The use of paraprofessional workers, or professional aides, has increased greatly in other fields of service with generally positive results and needs to be explored as well in this area. In all of these levels and patterns of training, special attention must be paid to the recruiting and inclusion of deaf people themselves in all facets of these programs, as trainees as well as trainers, as program directors and service providers as well as recipients of services.

Public Awareness

Another major area of need is in the development of public awareness of the mental health needs of deaf people and of the services available. There are many publics to be considered, and the manner of generating awareness must take into account the differing requirements of each group. Printed matter, television and other broadcast media, conferences and lectures, personal contact, and other information channels will need to reach these various audiences.

Deaf people need to learn of the existence and availability of mental health services in the places where they live and work and must learn to become sophisticated users of such services. Deaf people are no more free of stereotypes and misinformation than are the rest of us and need to receive basic informational and attitudinal messages. The staff, administration, and boards of directors of hospitals, clinics, Comprehensive Community Health and Mental Health Centers, private practice groups, and similar service programs need to become aware of the needs of deaf people in their areas of responsibility. State, city, county, and other legislatures, their staff members and the governmental employees in the executive bureaus and offices need to know of the existence and needs of their deaf citizens and taxpayers. The professional associations of many kinds whose members are engaged in mental health work are other target audiences which need periodic, timely reminders. The task is of enormous size, and there is little likelihood of a decline in the need for general information of this kind in the foreseeable future. The task is of such importance, moreover, that it cannot be left to the media and publicity specialists. Deaf people, their friends and families, and the professional work-

ers who serve them all have a responsibility to assist in this endless task.

Research

Throughout the conference the speakers and participants time and again were reminded of the limitations of knowledge in this field, of the unanswered (and the unasked) questions. An obvious first need is for the development of testing and evaluation materials and procedures, and of the normative information based on deaf people upon which to base interpretations of the evaluation results. There is a great need for the standardization of recording and reporting forms, so that elementary baseline information on the numbers and kinds of clients served can be developed. Because the numbers of deaf people are so small in relation to the entire population and because they are scattered throughout the country, the questions of numbers and kinds need to be addressed on a national scale. Critical studies of treatment outcomes and treatment/client-characteristic/problem-characteristic interactions all require the nationwide collaboration of all existing service programs in a data collection and research network. The general demand for program evaluation and accountability only points up still further the need for a wide variety of information which is still not available. Recall that this volume contains the first detailed directory of existing mental health service programs for deaf people; prior to this publication even this most elementary of all program information was simply unavailable in any single published source. It is obvious from this discussion that the need is for information which can be put to immediate use in diagnostic assessment, treatment planning, monitoring of treatment planning, monitoring of treatment progress and outcome, and program evaluation. The need, therefore, is for user-directed research with prompt and general dissemination of the results and findings. Not often have researchers been very nearly begged by practitioners to turn their attention to a set of problems, with a virtual guarantee that the findings and recommendations will be eagerly awaited and promptly put to use.

The interrelationships of the needed research endeavors with the other areas of immediate need, such as training, are readily apparent. The development of tests and objective norms becomes the content of teaching, on the one hand, and helps to facilitate the development of internal norms on the other. The results of treatment/

client-interaction studies will guide the nature of requests for funding for additional programs. The more that becomes known, the more extensive and sophisticated can be the contents of the public awareness messages for lay and professional publics. Research, then, in the sense meant here, is not an esoteric activity engaged in by academics primarily for their own benefit, but a user-directed set of activities which attempts to support and improve practice in a wide variety of ways.

In Conclusion

To sum up in brief, the times are now auspicious for a major effort toward the improvement and expansion of mental health services for deaf people, although success is not guaranteed. For the first time, by means of this conference, the people now engaged in the delivery of mental health services to deaf people met each other in person, discussed problems and practices, and came to some basic agreements or understandings of the major issues facing us in the next

few years. These are, first of all, the expansion of mental health services for deaf people in scope and in location. Second, there are many needs for a variety of levels and patterns of professional training, with deaf people included from the start as both trainers and trainees. Third, there is an enormous need to address informational and attitudinal messages about mental health services to deaf people themselves, to service providers and administrations, and to legislative and other governmental figures responsible for the establishment and execution of social policy. Finally, there is a broadly recognized need for a data collection and research network to link the existing and to-be-established mental health service programs and to provide those programs with the information, materials, and procedures, based upon solid research, which are needed to develop and improve service programs, and to evaluate and render an account for them.

The times are right, the needs are known and generally agreed upon. The challenge faces us. Will this volume prove to be midwife or mortician?

WELCOME AND BACKGROUND

Luther D. Robinson, M.D.

Dr. Robinson is Associate Superintendent of Saint Elizabeths Hospital and Special Assistant to the Director of the National Institute of Mental Health. He was the founder of the Mental Health Program for the Deaf at Saint Elizabeths Hospital.

It is indeed a great privilege and a pleasure to me to welcome all of you to this very momentous occasion. I am speaking for both Dr. Bertam S. Brown, the Director of the National Institute of Mental Health, and Dr. Roger Peele, the Acting Superintendent of Saint Elizabeths Hospital, when I extend to you a very warm welcome. Both of them are very much interested in the mental health of deaf people in general and in this workshop in particular, and both of them have given it their blessings.

This workshop is the brainchild of Dr. Thomas Goulder, Clinical Ward Administrator here in the Saint Elizabeths Hospital Mental Health Program for the Deaf. Working with him was Ms. Terry Edelstein, educational specialist in the program for emotionally disturbed deaf children of the Western Pennsylvania School for the Deaf.

I think it is quite appropriate to have this workshop at this time, in keeping with Mental Health Month, which is celebrated in May and designated by the National Association for Mental Health. This is also an historic occasion. It seems that the years of the 76's have their part in great achievements. In 1776 the United States achieved its independence. In 1876, the telephone was invented in the interests of helping deaf people, and now in 1976 the Orthopsychiatric Workshop on Deafness is being held at Saint Elizabeths Hospital. This program, these 2 days, should have a great deal of meaning for all of us who are involved in mental health efforts for deaf people. The coming together of different helping agencies of the Department of Health, Education, and Welfare, from the fields of mental health, rehabilitation, and education, with program staffs from Federal and State levels, is an indication of the tremendous degree of importance placed on this effort.

I am aware of the efforts devoted to mental health services for deaf people by the Vocational

Rehabilitation Administration, now Rehabilitation Services Administration, during the last half of this century. Prior to that time, it was left largely to educational programs to play a significant role in the prevention of mental health problems in deafness. The educational process has a role in the detection of deviant behavior; it has served as a case-finding method; and, of course, educational programs have also added psychological services to deal with these emotional problems. We are aware of the increased efforts of the Bureau of Education for the Handicapped to improve services in this area.

However, the landmark efforts in providing mental health services to deaf people came with the pioneering efforts of the New York State Psychiatric Institute under the leadership of the late Dr. Kallman in 1955 and subsequently carried on by Drs. Rainer and Altschuler. This program started with the support of a grant from VRA and continued for several years under that grant before being supported by the State of New York. In spite of the impact of that program, Saint Elizabeths' staff members had never heard of it when we started our Mental Health Program for the Deaf in 1963. In fact, we were well into the first phase of our program before we were aware that there were any other mental health programs for the deaf in the country. This was an indication of the need for more communication about what is being done in developing mental health services for deaf people.

So this workshop today will initially serve as a further step in communication for all of us, so that we will know more of what is going on in the field of developing mental health services for deaf people. The proceedings of this workshop will be published as the first issue of a regularly appearing journal or bulletin, on "Mental Health in Deafness," which Saint Eliza-

beths Hospital has recently established to communicate information to those of us who are involved in the field.

In closing, I want to thank all of you who have been of help to us at Saint Elizabeths for your coming here today for this workshop. I would like to mention particularly Saint Elizabeths' parent organization, the National Institute of Mental Health, which is playing a significant role in this workshop.

Finally, I hope that this workshop will achieve the goals which were set forth by Dr. Goulder and Ms. Edelstein when they planned it, namely, to develop a statement of national priorities of mental health needs of deaf adults and children; and second, to explore the potentials for development of comprehensive State planning for mental health services to deaf people.

THE ORIGINS AND PURPOSE OF THE ORTHOPSYCHIATRIC WORKSHOP

Thomas J. Goulder, Ph.D., and Terry J. Edelstein

Dr. Goulder and Ms. Edelstein were the originators and co-directors of the Orthopsychiatric Workshop on Deafness.

As the two of us went about our work of providing mental health services for deaf people, Tom in a hospital-based program for adults and adolescents in Washington, D.C., and Terry in a school-based program for children in Pittsburgh, Pennsylvania, it became more and more apparent that our situation was a general one. One of us worked here, the other worked there. In this case, we knew each other, and now and then corresponded or conferred by telephone to share ideas and questions, but we really did not have a clear idea of the other's work or problems or successes or questions. We began to wonder how many others there were in this country, also providing mental health services to deaf people in schools, clinics, hospitals, or wherever, who did not know each other, did not perhaps even know that there were others facing the same challenges. There was no journal, no association, no mechanism of any kind for all of us to meet each other, exchange information, and learn from each other. So we decided to do something about that.

This conference, the Orthopsychiatric Workshop on Deafness, is that something. We began by searching in as many ways as we knew how, to learn of the existence of other mental health programs for deaf people. We wrote letters, made telephone calls, asked friends and colleagues if they knew of other people involved in services to deaf people. Eventually we had what is probably the most complete available list of existing programs. It was obvious by that time that some kind of directory of these programs — giving name, location, and some elementary descriptive information about them — would be a genuine contribution to the advancement of

mental health services to deaf people. So we determined to collect this kind of directory information and put together a printed guide.

As we wrote and called around the country to obtain the information we needed for the directory, more and more of the people we contacted expressed surprise at the number of programs in existence. Their interest in what their newly discovered colleagues were doing was persistent, and even the promise of a copy of the directory was not sufficient. It began slowly to dawn on us that we needed to meet each other in person; that no real cohesiveness or sense of being a group of professional colleagues could be developed or maintained unless we met at some time. And so was born the plan for the Orthopsychiatric Workshop on Deafness.

With the invaluable and absolutely essential support and cooperation of Dr. Luther D. Robinson, Associate Superintendent of Saint Elizabeths Hospital, and of Dr. Doris Dickens, head of the Mental Health Program for the Deaf at Saint Elizabeths, we began the exciting work of arranging a national conference. All the mental health programs identified in the survey for a directory publication were contacted and invited to send one or more representatives to a national meeting. Representatives of the various branches and divisions of the National Institute of Mental Health (NIMH) agreed to attend and address the group, as did representatives of the Federal Rehabilitation Services Administration and the Bureau of Education for the Handicapped of the United States Office of Education. To sustain the momentum generated by the conference, approval was obtained from NIMH for printing of the proceedings of the

conference, as the first issue of a new professional journal, to be called *Mental Health in Deafness*. What began as a simple attempt to describe the current status of mental health services for deaf people has grown to a series of activities, including a national conference, a printed proceedings, and a continuing profes-

sional journal. It is our fond hope that these outgrowths of our initial ideas will continue and expand, so that deaf people will before long have equal access to mental health services of high quality, no matter where they live within these United States.

Part II
THE CURRENT STATUS OF
MENTAL HEALTH SERVICES
FOR DEAF PEOPLE

FEDERAL AND STATE MENTAL HEALTH PROGRAMS FOR THE DEAF IN HOSPITALS AND CLINICS

Thomas J. Goulder, Ph.D.

Dr. Goulder is director of a newly established community mental health center for deaf people at the Massachusetts Mental Health Center in Boston.

Dr. Sigmund Freud was once asked to define mental health. He responded by saying, "Mental health is the ability to work and to love." This statement is profound and it provides us with hope. It says to us that what we are doing in mental health is basic to living and being human. We are in the mental health profession and the objective of our endeavor is to assist men and women, boys and girls, in loving and working. We share with them our love, so that they might enter into the world as whole people. It has been said that children learn to love by being loved. As parents, educators, or as therapists we become parents of this kind of dream. We become the object that is loved. We impart to children or to those we are working with, consciously and unconsciously, our true self and, in doing so, we communicate the meaning of love. Mental health means the ability to love oneself and to love others. Freud's definition of mental health includes work. "Mental health means the ability to work." Work can be interpreted in several different ways. For children, playing can be considered work. For the school age youth, learning is work. As adults we invest our energy in meaningful, purposeful acts, and this becomes our work.

Today, we as workshop participants are in a work of love. This workshop is born out of realistically looking at people who need love and who need to know how to work.

I would like us to ask some universal questions of those who are in the field of mental health delivery services, educational settings, and vocational rehabilitation. First, look at our history. Where have we come from? What are we doing? Where are we planning to go, and, finally, how shall we arrive there? In an attempt to

answer these questions myself, I began to call many of you on the telephone. I started a telephone survey to find out what was happening on the West coast and in Texas, Minnesota, Ohio, North Carolina, and New York. I knew that you were out there in your office working just as I was working here in Washington, D.C. But what I didn't know, was what you were thinking and experiencing. I knew that I was worried as I looked around me at our mental health program and pondered on these questions: "What am I doing?" "Where am I going?" and I felt the need to communicate with you. This need led me to start telephoning you and from our conversations I developed a national survey form, which was mailed to you who were directors of mental health programs. Part of the data that I will present here are based on the data gathered from you by telephone and the data form.

Table 1 provides some estimate of the national need for mental health services for hearing impaired persons. The estimates of the size of the hearing impaired population are extrapolations of data published by the National Census of the Deaf Population. The extent of the need for mental health services in a population is estimated at 1 percent, 2 percent, and 10 percent by the National Institute of Mental Health, the three figures representing decreasing degrees of severity of the psychiatric problem and correspondingly different needs for services. It is apparent from this table that even using the most restricted estimate of need, and the smallest subgroup of hearing impaired people, the number of persons in need is in the thousands. As will be seen below, the number presently receiving service is in the hundreds only. As

Table 1. Need for mental health services among deaf people

Degree of hearing loss	Total number	Number needing services		
		1%	2%	10%
Hearing impaired	13,975,000	139,750	279,500	1,397,500
Significant bilateral loss	6,850,000	68,500	137,000	685,000
Deaf	1,850,000	18,500	37,000	185,000
Prevocationally deaf	430,000	4,300	8,600	43,000

more liberal estimates of need and larger segments of the hearing impaired population are considered, the size of the population needing service grows substantially.

Figure 1 shows graphically the history of the development of mental health services for deaf people. The first programs were established in 1963, the next few in 1968 and 1969, but it was not until 1973 that most of the presently existing programs opened their doors. It is obvious that this is a young field.

The size of the patient population served by the existing programs is shown in table 2. Separate consideration is given to inpatient and outpatient censuses, but the key figure is the bottom line: 727 deaf patients were being served at the time of this survey. Although this number will probably have grown somewhat by the time this reaches print, it is apparent from a comparison of table 2 with table 1 that only a small proportion of the need is being served. Using the smallest group, the prevocationally deaf, as a basis for computations, and the three NIMH estimates of need for mental health services, the following results are obtained: using a 1 percent estimate of need, the 727 people receiving service represent 17 percent of those in need; the other 83 percent of deaf people in serious need of hospitalization or other major service are not able to be served. Using the 2 percent estimate of need, the served group represents 8 percent of those in need; and using the 10 percent estimate of need, the people receiving services represent less than 2 percent of those in need. It is apparent that we have a long way to go simply in making services available to those deaf people who need them.

Who are the members of the staff of these programs? A listing of both full-time and part-time (or consulting) staff members is provided

Table 2. Patient populations of mental health programs for the deaf

Outpatients only		
Langley Porter	24	
Minn. Publ. Welf.	15	
	39	
Inpatients only		
Dixmont State	20	
Mendota State	13	
Western State	24	
Broughton State	30	
Central State	40	
	127	
Combined:	# Inpatients	# Outpatients
Rockland State	30	270
Saint Elizabeths	46	50
Michael Reese	3	20
Austin State	36	10
Resthaven	5	12
Columbus State	24	1
Fort Logan	10	9
St. Paul Ramsey	5	30
	159	402
Subtotal Inpatients	286	
Subtotal Outpatients	441	
Total patients being served	727	

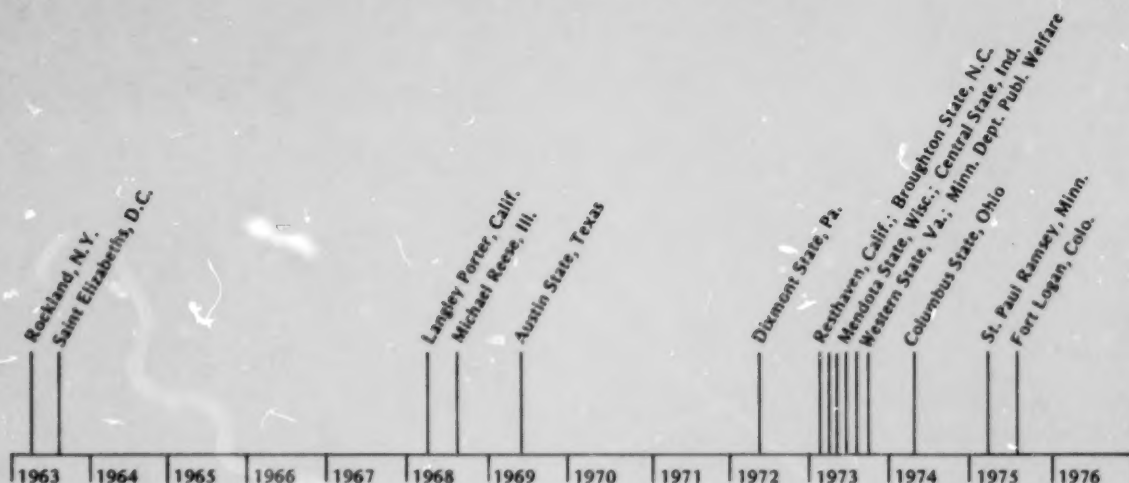


Figure 1. Chronology of establishment of mental health programs for the deaf

in table 3, using the position titles as supplied by the programs themselves. It is interesting to note that while a few deaf persons are involved (most frequently as program director or coordinator) on a full-time basis, none of the part-time professionals and only one nursing staff member are deaf themselves. Social workers and psychologists are the most frequently named full-time professionals, while psychiatrists are the most frequently employed part-time or consultant staff members.

It is quite apparent from figure 2 that the number of mental health programs is small and unevenly distributed across the United States. The largest number of programs is located in the Northeast region of the country, with very sparse coverage throughout most of the South and West. Maybe I can say that this map will serve as the bellwether of the success of this conference. If at some future conference of this sort a new map can be presented which would be so covered with X's and program names that it became hard to read, we could judge our success at least in expanding the availability of programs. As it is, 38 States, as of this writing, have no mental health services for deaf people. Few if any of the remaining 12 could claim that the services they do have are adequate to the needs.

Still, it would be unwise for us to look only at those persons who are already institutionalized and expend all our resources on this population. Our view must encompass the entire deaf population. It must include children in all types of educational facilities for the hearing impaired. It must look at the social systems in which hearing impaired children are raised and educated. Our approach must include preventive programs, crisis intervention programs, and comprehensive mental health services. The term, "comprehensive," as used here, means that our programs should provide inpatient care, outpatient services, services for children and their parents, training for staff and community members, and research that focuses on the issues confronting the field of deafness and mental health.

The word "Orthopsychiatric" in the title of this workshop implies that our concern is the total development of the deaf person. Our focus is on the person and his growth process.

The questions we shall try to answer are: How can we develop preventive programs? What are the optimal social environments for the education of hearing impaired children? What are the effective treatments for deaf persons who are emotionally disturbed? How can we organize ourselves into a working profession that recognizes the mental health needs of the deaf population?

Table 3. Mental health programs staffing

Title	# Full time	(#deaf)	# Part time	(#deaf)
Social worker	13	(1)	6	
Director/coordinator/administrator	9	(4)	1	
Psychologist	8	(2)	8	
Teacher/educational therapist	7		3	
Occup/recr/activity therapist	7		2	
Interpreter	5		3	
Clerk/secretary	5		—	
Psychiatrist	4		16	
Voc. rehab. counselor	3		1	
Physician (nonpsychiatric)	2		4	
Sign language specialist	1	(1)	—	
Housekeeper	1		—	
Researcher	1		—	
Nursing technician coordinator	1		—	
Therapy assistant	1		—	
Mental health worker	—		1	
Audiologist	—		1	
Total	68	(8)	46	
Registered nurse	21		6	
Licensed practical nurse	4		2	
Nursing assistant	104	(1)	3	
Total	129	(1)	11	

lation? How can we best deliver mental health services within the context of our regions? The answers to these questions are not to be found in Federal agencies such as NIMH, BEH, or RSA. These agencies may supply us with direction and special funding, but they, in and of themselves, are not the solution to the mental health needs of the deaf population.

Where is the solution? Well, it is like the man in South Africa who, during the days of the great gold and diamond discoveries, sold his 500-acre farm and went out in search of gold and diamonds. After 2 years of searching and finding nothing, he threw himself into the river

in despair and drowned. The man who bought his farm sold it to the government. Upon excavating the land, the government found the largest gold and diamond mines in all of South Africa on that poor man's property. The moral of the story is that the gold and diamonds are really under our own feet. The answers are in ourselves. Although here we may listen to what the Federal Government can and should do for us, it is really what we can do for ourselves that is important. I trust that throughout this day and tomorrow, and from now on, we will be searching for the answers within ourselves.



Figure 2. Location of mental health programs for the deaf

DIRECTORY OF HOSPITAL- AND CLINIC-BASED MENTAL HEALTH PROGRAMS FOR THE DEAF

Thomas J. Goulder, Ph.D.

Rockland Psychiatric Center
Department of Mental Hygiene
Orangeburg, New York 10962

Year established: 1963

INPATIENTS: 30

OUTPATIENTS: 270

PROFESSIONAL STAFF: 9 full time, 3 part time

Psychiatrist	1 ft, 3pt
Social worker	2 ft
Psychologist	2 ft
Teacher	1 ft
Occupational therapist	1 ft
Recreational therapist	1 ft
Vocational rehabilitation specialist	1 ft

NURSING STAFF:

Registered nurse	2 ft
Nursing assistant	15 ft

HEARING IMPAIRED STAFF MEMBERS: None

SERVICES AND TREATMENT PROVIDED:

Individual therapy	Family therapy
Group therapy	School consultation
Occupational therapy	Preventive services
Recreational therapy	Psychiatric counseling
Educational therapy	Children's day program
Day care	Vocational adjustment and placement

TRAINING PROVIDED: Inservice training in sign language; supervision of students in social work, psychology, vocational rehabilitation

FUNDING SOURCE: Initially Federal; currently State Department of Mental Hygiene

COST OF SERVICES: Not reported

ADMISSION REQUIREMENTS: Not reported

SPECIAL NEEDS: Residential home for young deaf; increased staff

Saint Elizabeths Hospital
 Mental Health Program for the Deaf
 Washington, D.C. 20032
 (202) 574-7218

Year established: 1964

INPATIENTS: 46

OUTPATIENTS: 50

PROFESSIONAL STAFF: 9 full time (ft), 1 part time (pt)

Psychiatrist	1 ft
Medical doctor	1 pt
Clinical administrator	1 ft
Program coordinator	1 ft
Social worker	1 ft
Psychologist	1 ft
Teacher	1 ft
Rehabilitation specialist	1 ft
Clerk	2 ft

NURSING STAFF:

Registered nurse	4 ft
Nursing assistant	26 ft

HEARING IMPAIRED STAFF MEMBERS: Two (social worker; psychologist)

SERVICES AND TREATMENT PROVIDED:

<i>Inpatient</i>	<i>Outpatient</i>	<i>Other Services</i>
Group therapy	Family therapy	Vocational rehab workshop
Industrial therapy	Individual therapy	Psychiatric evaluation
Psychodrama	Group therapy	School consultations
Art therapy	Chemotherapy	Workshops
Dance therapy		Half-way house
Occupational therapy		
Recreational therapy		
Educational therapy		
Individual therapy		
Chemotherapy		

TRAINING PROVIDED: Inservice training in American sign language; psychology of deafness seminars; supervision of students in social work (BA and MSW), counseling (MA), workshops for vocational rehab students, art therapy students, occupational therapy students, individualized programs

FUNDING SOURCE: General budget of hospital (funded by U.S. DHEW)

COST OF SERVICES: None to United States citizens

ADMISSION REQUIREMENTS: Patient should be willing to sign into hospital voluntarily; parent must sign if patient under 16 not suicidal or escape risk; not a serious management problem because custodial service is not rendered; should possess skill in sign language and fingerspelling (deaf lifestyle); program should be able to return patient to family or referral agency after maximum benefit has been reached.

SPECIAL NEEDS: Children's service, both inpatient and outpatient; increased staff and funding; research branch; day care program; comprehensive Federal plan for mental health services for the deaf

University of California
 Mental Health Services for the Deaf
 1474 Fifth Ave.
 San Francisco, California 94143
 (415) 731-9150

Year established: 1968

INPATIENTS: None

OUTPATIENTS: 24

PROFESSIONAL STAFF: 3 full time (ft), 6 part time (pt)

Psychiatrist	1 ft, 1 pt
Psychologist	2 pt
Social Worker	1 ft, 3 pt
Researcher	1 ft

NURSING STAFF: None

HEARING IMPAIRED STAFF MEMBERS: None

SERVICES AND TREATMENT PROVIDED:

Preschool research and demonstration
 School consultation
 Family consultation
 Child and adult diagnostic evaluation and treatment

TRAINING PROVIDED: Inservice training in American sign language

FUNDING SOURCE: S.R.S. & B.E.H. grants 1968-73; private funding; Federal grants; State department of health

COST OF SERVICES: Not reported

ADMISSION REQUIREMENTS: Not reported

SPECIAL NEEDS: Comprehensive community psychiatry plan for northern California; residential and adjustment centers for young adults; sponsoring trainee program

St. Paul Ramsey Hospital
 St. Paul, Minnesota
 (612) 222-4260

Year established: 1975

INPATIENTS: 5

OUTPATIENTS: 30

PROFESSIONAL STAFF: 5 full time (ft), 3 part time (pt)

Psychiatrist	1 pt
Clinical psychologist	1 ft
Coordinator	1 ft
Social worker	1 ft
Mental health worker	1 pt
Therapy assistant	1 ft
Psychiatric resident	1 pt
Interpreter	1 ft

NURSING STAFF: Registered nurse 3 ft
 Nursing assistant 4 ft

HEARING IMPAIRED STAFF MEMBERS: Two (clinical psychologist; mental health worker)

SERVICES AND TREATMENT PROVIDED:

Individual therapy
 Group therapy
 Family therapy
 Occupational therapy
 Recreational therapy
 Art therapy
 Consultation with St. Paul Technical Vocational Institute
 Preventive psychological work
 Psychological testing
 Alcohol and drug counseling

TRAINING PROVIDED:

Inservice sign language and general psychology; supervision of occupational therapy students, psychiatric residents, medical students, psychology graduate students

FUNDING SOURCE:

Ramsey County Mental Health Center; hospital budget; department budget; Medical Evaluation & Research Foundation

COST OF SERVICES:

Not reported

ADMISSION REQUIREMENTS:

Not reported

SPECIAL NEEDS:

After-care facilities; comprehensive State plan for mental health services; expanded educational and preventive services; primary care physicians

Fort Logan Mental Health Center
 Denver, Colorado

Year established: 1975

INPATIENTS:

10

OUTPATIENTS:

9

PROFESSIONAL STAFF:

2 full time (ft), 1 part time (pt)

Director	1 ft
Arizona University intern	1 ft
Psychiatrist	1 pt

NURSING STAFF:

Registered nurse	2 ft
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HEARING IMPAIRED STAFF MEMBERS: One (director)**SERVICES AND TREATMENT PROVIDED:**

Individual therapy
 Group therapy
 Vocational rehabilitation
 Home study
 Occupational therapy

TRAINING PROVIDED:

Supervision of Arizona University intern

FUNDING SOURCE:

Federal grant

COST OF SERVICES:

Not reported

ADMISSION REQUIREMENTS:

Not reported

SPECIAL NEEDS:

Increase staff; a facility; comprehensive State plan

Columbus State Hospital
Columbus, Ohio
(614) 466-5950

Year established: 1974

INPATIENTS: 24

OUTPATIENTS: 1

PROFESSIONAL STAFF: 7 full time (ft), 2 part time (pt)

Director	1 ft
Psychiatrist	1 pt
Psychologist	1 pt
Activity therapist	1 ft
Social worker	1 ft
Educational therapist	1 ft
Vocational rehabilitation counselor	1 ft
Clerk	1 ft
Housekeeper	1 ft

NURSING STAFF:

Registered nurse	1 ft
Nursing assistant	9 ft

HEARING IMPAIRED STAFF MEMBERS: None

SERVICES AND TREATMENT PROVIDED:

- Individual therapy
- Group therapy
- Activity therapy
- Art therapy
- Chemotherapy

TRAINING PROVIDED: Inservice training in American sign language

FUNDING SOURCE: Ohio mental health budget

COST OF SERVICES: Not reported

ADMISSION REQUIREMENTS: Not reported

SPECIAL NEEDS: Increase in nursing staff; general development of program

Resthaven Psychiatric Hospital
Los Angeles, California
(213) 626-8241

Year established: 1973

INPATIENTS: 5

OUTPATIENTS: 12 per day

PROFESSIONAL STAFF: 9 full time (ft), 4 part time (pt)

Director	1 ft
Psychologist	2 pt
Social worker	1 ft
Psychiatrist	1 ft
Educational therapist	1 ft
Occupational therapist	1 ft
Interpreter	3 ft, 2 pt
Secretary/office manager	1 ft

HOSPITAL AND CLINIC DIRECTORY

23

NURSING STAFF: Registered nurse 1 ft, 1 pt
Nursing assistant 2 ft, 2 pt

HEARING IMPAIRED STAFF MEMBERS: One (director)

SERVICES AND TREATMENT PROVIDED:

Inpatient & Day Treatment

Group psychotherapy
Individual psychotherapy
Psychodrama
Body movement therapy
Art therapy
Arts and crafts
Recreational therapy
Educational therapy
Work evaluations
Family therapy

Outpatient

Parent group therapy
Individual psychotherapy
Recreational therapy
Work evaluations
Family therapy

Rehabilitation

Work evaluation
Adjustment of daily living

TRAINING PROVIDED: Inservice training in American sign language; use of interpreters in the psychiatric setting; seminars on psycho-social dynamics of deafness

FUNDING SOURCE: State department of health

COST OF SERVICES: Not reported

ADMISSION REQUIREMENTS: Not reported

SPECIAL NEEDS: Community living resources; more extensive children's services

State of Minnesota
Department of Public Welfare
St. Paul, Minnesota 55155
(612) 296-3472

Year established: 1973

INPATIENTS: None

OUTPATIENTS: 15

PROFESSIONAL STAFF: 2 full time (ft)

Coordinator 1 ft
Interpreter 1 ft

NURSING STAFF: None

HEARING IMPAIRED STAFF MEMBERS: One (coordinator)

SERVICES AND TREATMENT PROVIDED:

Individual therapy
Mental health consultation and collaboration with 12 State institutions and many service organizations

TRAINING PROVIDED: Inservice program for hospital personnel; American sign language

FUNDING SOURCE: State budget

COST OF SERVICES: Not reported

ADMISSION REQUIREMENTS: Not reported

SPECIAL NEEDS: Inpatient ward soon; group residence facility for mentally retarded patients; comprehensive state-wide plan for mental health services to deaf persons; preventive program for school children

Central State Hospital
Indianapolis, Indiana
(317) 637-5511

Year established: 1973

INPATIENTS: 40

OUTPATIENTS: Some

PROFESSIONAL STAFF: 4 full time (ft), 3 part time (pt)

Director	1 ft
Social worker	1 ft
Activity therapist	1 ft
Secretary	1 ft
Psychiatrist	1 pt
Psychologist	1 pt
Social worker	1 pt

NURSING STAFF:

Registered nurse	1 ft, 1 pt
Nursing assistant	9 ft

HEARING IMPAIRED STAFF MEMBERS: One (director)

SERVICES AND TREATMENT PROVIDED:

- Individual therapy
- Group therapy
- Family therapy
- Psychodrama
- Chemotherapy
- Activity therapy

TRAINING PROVIDED: American sign language training provided to Gallaudet students

FUNDING SOURCE: Private grant; Federal; general hospital budget

COST OF SERVICES: Not reported

ADMISSION REQUIREMENTS: Not reported

SPECIAL NEEDS: Comprehensive State plan for mental health services as part of the ongoing State program

Broughton State Hospital
Morganton, North Carolina
(704) 433-2111

Year established: 1973

INPATIENTS: 30

OUTPATIENTS: None

PROFESSIONAL STAFF: 1 full time (ft), 3 part time (pt)

Psychologist	1 ft
Medical doctor	1 pt
Social worker	1 pt
Recreational therapist	1 pt

NURSING STAFF:

Registered nurse	1 pt
Nursing assistant	11 ft

HEARING IMPAIRED STAFF MEMBERS: None

SERVICES AND TREATMENT PROVIDED:

Group therapy
Individual therapy
Recreational therapy
Art therapy
Work experience in and out of hospital

TRAINING PROVIDED: Sign language workshops

FUNDING SOURCE: General hospital budget

COST OF SERVICES: Not reported

ADMISSION REQUIREMENTS: Not reported

SPECIAL NEEDS: Comprehensive State plan for mental health services for the deaf

Western State Hospital

301 Greenville Avenue
Staunton, Virginia 24401

Year established: 1973

INPATIENTS: 24

OUTPATIENTS: None

PROFESSIONAL STAFF: 2 full time (ft), 4 part time (pt)

Medical doctor	2 ft
Psychiatrist	1 pt
Psychologist	1 pt
Social worker	1 pt
Coordinator	1 ft
Rehabilitation specialist	1 pt

NURSING STAFF:	Registered nurse	1 ft, 2 pt
	Licensed practical nurse	1 ft, 2 pt
	Aides	11 ft

HEARING IMPAIRED STAFF MEMBERS: One (Aide)

SERVICES AND TREATMENT PROVIDED:

Individual therapy
Group therapy
Vocational training
Chemotherapy
Recreational therapy
Occupational therapy

TRAINING PROVIDED: Sign language undergraduate training

FUNDING SOURCE: General hospital budget

COST OF SERVICES: \$22 per day

ADMISSION REQUIREMENTS: Between ages 14 and 60; in reasonably good physical condition; should have at least a third-grade education; should have complete mental and physical workup prior to transfer; current audiogram should accompany the transfer; should be a real hearing problem not corrected by the use of a hearing device; deafness should be the client's lifestyle; should be mentally ill to a degree requiring mental hospitalization; should be able to use manual communication skills or be capable of learning them; patient and family should agree to patient entering deaf program voluntarily.

SPECIAL NEEDS: Comprehensive State plan for mental health services
Adult educational service teacher
General increase of funding and staff

Deaf Treatment Center
 Mendota Mental Health Institute
 301 Troy Drive
 Madison, Wisconsin 53704
 (608) 244-2411

Year established: 1973

INPATIENTS: 13 adolescents and adults

OUTPATIENTS: None

PROFESSIONAL STAFF: 5 full time (ft), 2 part time (pt)

Unit chief, social worker	1 ft
Psychologist	1 ft
Social worker	1 ft
Recreational therapist	1 ft
Teacher	1 ft
Psychiatrist	1 pt
Physician	1 pt

NURSING STAFF:

Registered nurse	5 ft
Licensed practical nurse	3 ft
Nursing assistant	3 ft

HEARING IMPAIRED STAFF MEMBERS: None

SERVICES AND TREATMENT PROVIDED:

Case management and advocacy
 Chemotherapy
 Coordination of vocational training
 Crisis intervention
 Daily living skills training
 Day care
 Education
 Evaluation/Diagnosis
 Individual and group therapy
 Industrial therapy available
 Occupational therapy available
 Recreational therapy
 Social skills training
 Case consultation with community agencies
 Workshops on working with deaf clients
 Workshops on communications

TRAINING PROVIDED:

To staff: American sign language; deafness, its problems, and treating mental patients.
 To students: affiliations in social work, recreational therapy, occupational therapy, counseling, communicative disorders, dance therapy, less intensive educational experience for medical students.

FUNDING SOURCE: State mental hygiene budget

COST OF SERVICES:

Inpatient service: \$92 per day
 Outpatient service: \$7.25 per quarter hour
 Day care: \$6 per hour
 Consultation and training to agencies: no charge

ADMISSION REQUIREMENTS: For inpatients: residence in Wisconsin; ages 13 through adulthood; referral approved by physician; psychiatric disturbance; approval of local mental health board.

SPECIAL NEEDS:

Community living resources and after-care
 Comprehensive State plan and funding
 Prevention
 Children's services

Dixmont State Hospital
Western, Pennsylvania
(412) 761-1780

Year established: 1972

INPATIENTS: 20

OUTPATIENTS: None

PROFESSIONAL STAFF: 1 full time (ft), 6 part time (pt)

Psychiatrist	1 pt
Psychologist	1 pt
Educational therapist	3 pt
Activity therapist	1 pt
Social Worker	1 ft

NURSING STAFF:

Registered nurse	1 ft
Nursing assistant	3 ft

HEARING IMPAIRED STAFF MEMBERS: None

SERVICES AND TREATMENT PROVIDED:

- Recreational therapy
- Activity therapy
- Educational therapy
- Religious instruction
- Daily living skills
- Individual therapy

TRAINING PROVIDED: Sign language; psychosexual development; counseling practicum for university students

FUNDING SOURCE: General hospital budget

COST OF SERVICES: Not reported

ADMISSION REQUIREMENTS: Not reported

SPECIAL NEEDS: More specialized staff

Austin State Hospital
Center for the Deaf
Austin, Texas 78751

Year established: 1969

INPATIENTS: capacity for 36

OUTPATIENTS: approximately 10, but only those who have been in the inpatient program

PROFESSIONAL STAFF: 4 full time (ft), 2 part time (pt)

Psychologist	1 ft
Social worker	1 ft
Recreational/occupational therapist	1 ft
Nursing technician coordinator	1 ft
Interpreter	1 pt
Psychiatrist	1 pt

NURSING STAFF:

Registered nurse	1 pt
Psychiatric nursing assistant	11 ft, 1 pt

HEARING IMPAIRED STAFF MEMBERS: None

SERVICES AND TREATMENT PROVIDED:

- Individual therapy
- Group therapy
- Educational therapy
- Recreational therapy
- Occupational therapy
- Chemotherapy
- Vocational rehabilitation
- Halfway house
- Some family consultation
- Consulting with other agencies as necessary

TRAINING PROVIDED: Inservice training in American sign language; occasionally have nursing students, psychology interns, psychiatry residents

FUNDING SOURCE: Grant from Department of Vocational Rehabilitation

COST OF SERVICES: According to accounting office; this is the hospital's charge.

ADMISSION REQUIREMENTS: Texas resident, 16 years of age or older, deafness or hearing impairment severe enough to preclude being able to benefit from services in a nontotal communication environment.

SPECIAL NEEDS: State plan for mental health services

Michael Reese Hospital
 29th Street and Ellis Avenue
 Chicago, Illinois 60616
 (312) 791-2000

Year established: 1968

INPATIENTS: 3 at any one time, for short-term crisis intervention, treatment, or diagnosis

OUTPATIENTS: 90

PROFESSIONAL STAFF: 6 full time (ft), 5 part time (pt)

Director	1 pt
Social worker	1 ft
Psychologist	1 ft
Educational therapist	2 ft
Psychiatrist	3 pt
Neurologist	1 pt
Audiologist	1 pt
Sign language specialist	1 ft

NURSING STAFF: Yes, but the hospital operates on the unit concept, and nursing staff are not specifically assigned to the deaf project.

HEARING IMPAIRED STAFF MEMBERS: One (sign language specialist)

SERVICES AND TREATMENT PROVIDED:

- Medical and psychiatric comprehensive evaluation
- Educational therapy
- Community psychiatry
- School consultation
- Family counseling
- Crisis intervention
- Individual insight-oriented therapy
- Parent-infant program

TRAINING PROVIDED: Inservice training in American sign language and total communication.

FUNDING SOURCE: Illinois Department of Mental Health

COST OF SERVICES: Hospitalization, \$140

ADMISSION REQUIREMENTS: Open to all residents of Illinois

SPECIAL NEEDS: Additional funding for program and staff for outpatient work; long-term care facility; halfway house.

SCHOOL-BASED TREATMENT PROGRAMS FOR EMOTIONALLY DISTURBED DEAF CHILDREN

Terry J. Edelstein

Ms. Edelstein is a specialist in the program for emotionally disturbed deaf children at the Western Pennsylvania School for the Deaf. She is currently enrolled in the doctoral program in special education at the University of Pittsburgh.

It has been well documented that the deaf child encounters unique stresses in each stage of development and that it is of critical importance to safeguard these developmental processes. It has also been established that a significant proportion of deaf children manifest serious emotional or behavioral disorders (Meadow and Schlesinger 1971; Jensema and Trybus 1975). Yet, research on the treatment of emotional problems among deaf children has been limited and, until recently, nonexistent. Today the majority of the 5,000+ deaf children with emotional problems still remain without specific treatment.

Though their numbers are limited, there are some special educational programs which have developed effective treatment programs for deaf children with emotional disturbances. This paper will report the results of a national survey which was undertaken to locate and describe such programs and thus provide a "state-of-the-art" summary of where we stand today.

The objective of the survey was to obtain descriptive information of program nature, clientele, staffing, and operations. The survey form was sent to more than 80 institutions in 28 States, identified through various published and informal sources as having, or possibly having, a program for emotionally disturbed deaf children. Responses were received from all 80 sources. It is, of course, possible that there are programs in existence beyond those contacted, but no other potential sources could be identified at the time of this survey.

A number of problems became apparent as the survey returns were examined. Definitions of "emotionally disturbed" and "deaf" varied

greatly, as did the definition of what constituted a "treatment program" for such youngsters. Most programs seem to have developed in isolation from one another, the staff of one program often being unaware of the existence of another program within the same State. This situation has certainly contributed to the lack of consensus on the meanings of key terms.

Program Types and Clientele Served

Two broad program types were distinguished. The first type consisted of programs or units intended specifically for emotionally disturbed deaf children, usually located within schools for the deaf. These will be referred to as ED programs. The second program type consisted of schools or programs which served children who were deaf and emotionally disturbed and who have other handicaps as well. These will be referred to as MH/ED programs. Given the definitional problems referred to earlier, this classification is not hard and fast and could be organized otherwise if a slightly different perspective were employed. The attempt to classify was not abandoned, however, because various aspects of program goals, methods, and staffing differed for the two program types.

Figure 1 shows the locations of the 11 programs classified as ED. These operated as self-contained units within a school for the deaf or a special institute. Many were initiated by a particular staff member with some interests and skill in serving children with the dual problem of deafness and emotional disturbance. In a few instances the school sought out new staff to develop services for increasing numbers of



Figure 1. Location of ED programs

children with adjustment and behavior problems. Children in these ED programs are generally of normal intelligence and were referred to the special unit when the emotional disturbance was of such a nature or degree that it interfered greatly with the child's ability to get along in the original class placement. Treatment goals generally focused on improving the child's emotional and social functioning to the point where the child could return to the mainstream of life in school and at home. A total of 215 children were receiving service, either full time or part time, in these 11 ED programs. Services were provided by 186 professional staff members, more than half of whom were employed on a part-time or consulting basis.

Eight programs in the second, or MH/ED category, were identified; their locations are shown in figure 2. Mental retardation was one of the handicaps for most of these children. In most cases, the treatment provided to the children in these programs was on an individually tailored basis, and children with the handicaps of deafness and emotional disturbance were not grouped apart from children with other particular combinations of handicaps. A few programs did establish special groups or classes for emotionally disturbed deaf children when their numbers warranted. Usually, however, such classes were meant to respond only to the needs of currently enrolled children, and new referrals specifically to such classes were not generally encouraged. Program goals were generally stated as academic growth, life skill development, and modification of inappropriate behavior patterns. These eight programs enrolled 119 students at the time of the survey. Professional staff numbered 89, with about one-third of these employed on a part-time or consulting basis.

In summary, these 19 programs were serving 334 emotionally disturbed deaf children with 140 full-time and 135 part-time professional staff from a variety of disciplines. Most of the programs were small, averaging 20 students in the ED programs and 15 in the MH/ED projects, and most concentrated on the 6-18 age group. Both program types employed the equivalent of one full-time staff person for about every three children served. As is apparent from the figures, about two-thirds of the programs are located in the northeast region of the United States, with only sparse service availability elsewhere. Many survey respondents noted that they served only as many students as their staff could accommodate and that they realized that

the number being served is far below the number who need such specialized services or who could be expected to benefit from them.

Treatment Approaches and Staffing Patterns

There was substantial diversity among the 19 programs as to treatment approaches, living arrangements, educational procedures, and staffing patterns. Half the programs used a self-contained therapeutic classroom approach, which combined both educational and treatment features into classroom activities. The milieu approach was next most frequently employed, the term referring to a planned combination of treatment, academic work, and supervised living arrangements. A small number of programs used a resource room approach, with the resource clinician providing direct therapy to the child as well as advice and consultation to other staff members who work directly with the child. A few programs referred to crisis intervention services, by which was meant additional support to the child and/or staff members at a point of particular difficulty within the regular treatment program. Consultation and evaluation services were provided to the staff of other agencies by only a few of these programs.

Clinical staff in more than half of the programs relied heavily on four major techniques: total communication, behavior management, prescriptive programming, and parent and family counseling. Smaller numbers of programs made use of individual therapy, group therapy, play therapy, relationship therapy, personal counseling, and drug treatment. Psychodynamic techniques were usually employed only with children of normal intelligence, while behavior management strategies were used especially with mentally retarded children.

Full-time staff in these programs tended to be aides, dormitory staff, educational specialists, and special education teachers (see table 1). In a few programs, full-time staff included child care workers, counselors, psychologists, and social workers. Part-time or consulting staff tended to be psychiatrists, psychologists, social workers, and other therapists. Only one-third of the ED programs, and none of the MH/ED programs, employed full-time personnel from these four specialty areas. Educational specialists were most often found in MH/ED programs, while professionals with psychosocial or psychodynamic orientations were usually found in the ED programs. Most respondents cited a need for



Figure 2. Location of MH/ED programs

Table 1. Professional staff of school-based treatment programs

Position title	Total number	Number full time	Number part time
Special education teacher	66	56	10
Dormitory staff	33	27	6
Aide	30	27	3
Psychologist	20	4	16
Educational specialist	19	13	6
Administrator	15	9	6
Social worker	12	3	9
Therapist	11	1	10
Psychiatrist	10	0	10
Vocational specialist	7	0	7
Counselor	6	4	2
Audiologist	6	1	5
Consultant	4	0	4
Behavior specialist	3	0	3
Child care worker	3	3	0
Nurse	3	1	2

more expert consultation and more specially trained staff.

Not surprisingly, the professional background and orientation of the clinical coordinator of a program exerted substantial influence on the design and structure of the program and on the approaches and techniques used. Williams (1970) and Schlesinger and Meadow (1972) suggest that this is one aspect of the appropriate tailoring of programs to the intellectual and other needs and capacities of the persons being served.

Each of the programs surveyed developed differently as the result of the interplay of many factors, including the availability of trained staff and the nature of their abilities and interests; funding method and commitment of the parent institution to the ED or MH/ED project; the needs of the children to be served; and the manner of assigning and coordinating therapeutic, residential, and educational responsibilities. All these factors must be kept in mind in planning for new treatment programs and in establishing appropriate kinds and levels of professional training for service providers. What kinds of service are best suited to which children? What kinds of personnel can best provide these services? What standards should apply in clinical training? How can treatment programs and the

results they produce be fairly judged? All these are questions of prime importance to the further development of adequate and comprehensive services to emotionally disturbed deaf children.

Relationship of the ED Program to the Parent Institution

The character of ED or MH/ED programs is, not surprisingly, greatly influenced by the nature of the parent institution or agency. The kinds of children enrolled in the parent facility determine the kinds of modeling, reintegration, and social environments which are open to children in the ED program. Parent institutions also vary in the extent to which ED program staff can influence or control the residential or educational setting into which they reintegrate an emotionally disturbed child. These factors determine the extent to which the larger program can, in effect, become part of the ED or MH/ED treatment program.

Most ED and MH/ED programs integrated their students with the larger student body of the parent facility for at least some activities. Only a few such programs operated as isolated units, maintaining no real contact with other functions of the parent facility. Two kinds of

Table 2. Summary of treatment program characteristics

Characteristic	ED Programs	ED/MH Programs
Number of programs	11	8
Number of children	215	119
Total number of staff	186	89
Percentage of staff on part-time basis	53%	33%
Ratio of full-time staff to students	1:3	1:3
Usual age range of students	6-12	6-12
Average number of students per program	20	15
Number of residential programs	7	6
Number of day programs	8	4
Funding support	State, Federal	State, Federal
Handicapping conditions	Deafness Emotional disturbance	Deafness Emotional disturbance Mental retardation
Program design	Milieu approach Therapeutic classroom	Therapeutic classroom
Therapeutic techniques	Psychosocial Behavior management	Educational Behavior management
Communication mode	Total communication	Total communication
Primary staff assigned	Clinical specialists	Educational specialists
Parent institution	Res. sch. for deaf Day programs	Res. sch. for deaf Res. sch. for multiply handicapped

settings accounted for most of the children being served: ED units in residential schools for the deaf (which operated both day and residential treatment programs); and units for multiply handicapped students (MH/ED) within schools for the deaf or special institutes for the multiply handicapped which accommodated students with emotional disturbances. About a quarter of the disturbed deaf children were enrolled with hearing students in schools or programs intended for a variety of multiply handicapped children. In some situations a special class for deaf children was established within such programs. Many of these treatment programs were financed by the same State or local

funds which supported the parent facility; about an equal number were supported by special Federal grants.

The ED and MH/ED programs which responded to this survey have shown that such programs can work well within a parent facility. The staff of these units have found it possible to use personnel and facilities of the larger program to amplify and support their therapeutic objectives with the disturbed children. Particularly when the parent facility is a school for the deaf, there is a realistic and manageable social setting into which the disturbed child can be gradually and usefully reintegrated (or perhaps integrated for the first time). The success of

such maneuvers depends not only on the readiness of the disturbed child, but on the readiness of the staff and the children in the parent facility. This readiness of the larger program can be much enhanced by deliberate activities of the ED program staff to inform, assist, support, and negotiate with staff of the parent facility.

A View to the Future

How does the number of children receiving services compare with the number who stand in need? Estimates of the prevalence of emotional disturbances among hearing impaired children range from about 9 percent (Jensema and Trybus 1975) to 22.6 percent (Freeman, Malkin, and Hastings 1975). Applying the conservative 9 percent figure to a base population of about 60,000 children in special educational programs for the hearing impaired yields an estimate of about 5,400 children needing services (this does not take into account those children who are in no school or program of any sort; cf. Schein 1975). The 334 children being served thus account for only 6 percent of those in need, by the most conservative estimate. Obviously, we have a long way to go. In addition to these general figures, there are special concentrations of need among those children deafened by maternal rubella in the 1958-59 and 1964-65 epidemics. These groups are numerically larger than

groups of deaf children born in other years and also exhibit higher rates of most handicapping conditions, including emotional and behavioral disturbances. No programs specifically for preschool children were located. Similarly, few programs were serving the 1958-59 rubella group, although rehabilitation services probably are involved with them to a substantial degree.

Conclusion

Historically, the educational institutions have been the dominant influence in the life of the deaf child. The advent of Public Law 94-142, mandating the availability of free, public education for all handicapped children, places responsibility for services to handicapped children squarely on the shoulders of the chief State school officer, and reaffirms the school as society's primary agent for insuring the optimum growth and development of handicapped children. As the schools thus expand their role and enter into new areas of service, the time is ripe for insuring the availability, in quality and in quantity, of educational and treatment services for emotionally disturbed deaf children. The time is at hand for a pooling of resources and a collaboration across disciplines, in the interests of providing competent and comprehensive mental care to deaf children.

Table 3. Summary of children needing service and receiving service

Type of facility	Being served*			Needing service**
	ED	ED/MH	Total	
Residential school for the deaf	111	51	162	1,336
Full-time special education classes	13	3	16	1,099
Day school for the deaf	30	0	30	320
Part-time special education classes	0	0	0	200
Residential program for multiply handicapped	27	74	101	123
Day program for multiply handicapped	14	21	35	98
All other types	0	0	0	262
Total	195	149	344	3,438

Data Sources:

*Survey of School-Based Treatment Programs, Edelstein

**Jensema and Trybus 1975

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DIRECTORY OF SCHOOL-BASED TREATMENT PROGRAMS FOR EMOTIONALLY DISTURBED DEAF CHILDREN

Terry J. Edelstein

Directory Part A: Special Treatment Programs

Maryland School for the Deaf

P.O. Box 894
Columbia, Maryland
(301) 465-9611
Nita Minton, Coordinator

Year established: 1974
(Frederick campus 1971)

CHILDREN SERVED:	20 full time, 16 part time age range 4 to 12
TYPE OF FACILITY:	Day and residential; public support; for multiply handicapped Deaf children only Primary, elementary, secondary
PROGRAM DESIGN:	Self-contained classes, resource room, total milieu
PROFESSIONAL STAFF:	24 full time (ft), 5 part time (pt)
	Assistant principal 1 ft
	Teacher 5 ft
	Teacher aide 6 ft
	Dorm staff 9 ft
	Psychologist 1 ft, 1 pt
	Psychiatric nurse 1 ft
	Secretary 1 ft
	Speech pathologist 1 pt
	Behavior consultant 1 pt
	Audiologist 1 pt
	Pediatrician 1 pt
SERVICES AND TREATMENT PROVIDED:	
Educational program	Frederick campus: Play therapy
Prescriptive programming	Individual therapy
Psychological services	Group therapy
Speech therapy	Family counseling
Physical therapy	
Audiological services	
Medical services	
Parent counseling	
Parent group meeting	

- TRAINING PROVIDED:** *Inservice:* behavior modification, individualized instruction, diagnostic teaching, media, child development, human relations to dorm staff and parents
Outservice: Gallaudet students for practicum
- FUNDING SOURCE:** State
- SPECIAL NEEDS:** Comprehensive plan; education and training programs; summer programs; curriculum development; prevocational objectives; information about other programs

Western Pennsylvania School for the Deaf

300 Swissvale Ave.
 Pittsburgh, Pennsylvania 15218

(412) 371-7000
 Terry Edelstein, coordinator

Year established: 1973

- CHILDREN SERVED:** 11 part time
 age range 6 to 17
- TYPE OF FACILITY:** Residential, publicly supported
 Deaf children only
 Primary, elementary, secondary
- PROGRAM DESIGN:** Resource room, total milieu, consultation
- PROFESSIONAL STAFF:** 1 full time (ft), 33 part time (pt)
- | | |
|----------------------------|------|
| Therapist-consultant | 1 ft |
| Academic teacher | 9 pt |
| Vocational teacher | 6 pt |
| Residence staff | 6 pt |
| Fine arts teacher | 4 pt |
| Physical education teacher | 3 pt |
| Psychologist | 1 pt |
| Audiologist | 1 pt |
| Home/school visitor | 1 pt |
| Administrator | 1 pt |
| Consultant | 1 pt |

SERVICES AND TREATMENT PROVIDED:

- | | |
|------------------------------------|------------------------------------|
| Therapy program | Milieu |
| Resource room | Integration-classroom |
| Relationship therapy | Dormitory environment modification |
| Play therapy | Behavior modification |
| Life-space intervention | Crisis intervention |
| Psycho-educational therapy | Individualized curriculum |
| Social-community awareness program | Weekly consultation |
| Communication development | |
| Daily intervention | |

- TRAINING PROVIDED:** *Inservice:* consultation to integrating staff; personality development; curriculum development; behavior management.
- FUNDING SOURCE:** State and general school budget
- SPECIAL NEEDS:** Comprehensive programming for emotionally disturbed deaf children; regional psychiatric short-term treatment facility; specially trained therapists to expand services

Beverly School for the Deaf

6 Echo Ave.
Beverly, Massachusetts 01915
(617) 927-7070
Herbert Goldberg, coordinator

Year established: 1974

CHILDREN SERVED: 9 full time
age range 4 to 10

TYPE OF FACILITY: Day and residential, privately supported
Both deaf and hearing children
Primary, elementary

PROGRAM DESIGN: Self-contained classes, total milieu, consultation, evaluation

PROFESSIONAL STAFF: 6 full time (ft), 3 part time (pt)

Director	1 ft
Teacher	2 ft
Learning disability teacher	1 ft
Resident counselor	2 ft
Pediatrician	1 pt
Clinical psychologist	1 pt
Clinical audiologist	1 pt

SERVICES AND TREATMENT PROVIDED:

Diagnostic-prescriptive training
Behavior modification
Diagnostic evaluation team
Parental participation in program monthly
Play therapy
Individual instruction
Small group social interaction
Video taping
All communication modes

TRAINING PROVIDED: Inservice: consultants to staffing

FUNDING SOURCE: Federal

SPECIAL NEEDS: Program expansion to include increased numbers and younger ages

**Boston College Campus School
for Multiply Handicapped Children**

213 Roberts Road
Chestnut Hill, Massachusetts 02167
(617) 969-0100, ext 2455
Jan Campanella, coordinator

Year established: 1969

CHILDREN SERVED: 14 full time
age range 4 to 19

TYPE OF FACILITY: Day school, privately supported, for multiply handicapped
Both deaf and hearing children
Primary, elementary, secondary

PROGRAM DESIGN: Self-contained classes

PROFESSIONAL STAFF: 6 full time (ft), 9 part time (pt)

Teacher	3 ft
Teacher aide	3 ft
Principal	1 pt

Nurse	1 pt
Shop teacher	1 pt
Counselor	1 pt
Parent program coordinator	1 pt
Psychiatrist	1 pt
Psychologist	1 pt
Social worker	1 pt
Physical therapist	1 pt

SERVICES AND TREATMENT PROVIDED:

Individualized academic program
Counseling
Psychiatric evaluation and treatment
Psychological evaluation and treatment
Preadademic program
Parent program

TRAINING PROVIDED:

Inservice: manual communication
Outservice: student teaching internship

FUNDING SOURCE:

Federal grant, P.L. 89-313, chapter 766, 750

SPECIAL NEEDS:

Program expansion in other areas, so emotionally disturbed population will reduce itself and be referred to other agencies

Crotched Mountain Center

Greenfield, New Hampshire 03447

(603) 547-3311

Kenneth Mann, superintendent

Year established: 1976

CHILDREN SERVED:

12 full time
age range 5 to 12

TYPE OF FACILITY:

Residential, privately supported, for multiply handicapped
Both deaf and hearing children
Primary, elementary, secondary

PROGRAM DESIGN:

Self-contained classes, total milieu

PROFESSIONAL STAFF:

7 full time (ft), 7 part time (pt)	
Teacher	2 ft
Teacher aide	2 ft
Dorm counselor	2 ft
Psychologist	1 ft, 1 pt
Educational consultant	1 pt
Behavioral consultant	1 pt
Secretary	1 pt
Speech therapist	1 pt
Occupational therapist	1 pt
Physical therapist	1 pt

SERVICES AND TREATMENT PROVIDED:

Behavior modification	Social recreational skill program
Managed environment: dormitory, classroom, home	Manual communication
Individual curriculum	Supervisor: student ratio 1:2
Individual behavior therapy	Twelve-month program
Evaluation	

TRAINING PROVIDED:

Inservice: curriculum, behavior management, parent training

FUNDING SOURCE:

Tuition, State medical agencies, endowment

SPECIAL NEEDS:

Utilization of the facility for larger population

Mystic Oral School for the Deaf

Mystic, Connecticut 06355

(203) 536-4221

Pat Blank, coordinator

Year established: 1972

CHILDREN SERVED: 5 full time, 5 part time
age range 8 to 10

TYPE OF FACILITY: Day and residential, publicly supported
Both deaf and hearing children
Primary, elementary, secondary

PROGRAM DESIGN: Self-contained classes; total milieu

PROFESSIONAL STAFF: 3 full time (ft), 6 part time (pt)

Teacher	1 ft
House parent	1 ft
Teacher aide	1 ft
Psychiatric consultant	1 pt
Media specialist	1 pt
Psychologist	1 pt
Learning disabilities specialists	1 pt
Reading specialist	1 pt
Administrator	1 pt

SERVICES AND TREATMENT PROVIDED

Psycho-educational academic program
Comprehensive behavior modification
Oral communication
Play therapy
Video taping for behavior recording
Daily individual therapy for learning problems
Program for autistic language impaired

TRAINING PROVIDED: *Inservice:* behavior modification
Outservice: weekly parent home training and behavior management

FUNDING SOURCE: Federal Title I

SPECIAL NEEDS: More trained staff; full-time psychiatrist

Lexington School for the Deaf

30th Ave. and 75th St.

Jackson Heights, New York

(212) 899-8800

Lauraine Effress, coordinator

Year established: 1974

CHILDREN SERVED: 50 part time
age range 6 to 19

TYPE OF FACILITY: Day and residential, publicly supported
Deaf children only
Primary, elementary, secondary

PROGRAM DESIGN: Self-contained classes, consultation, evaluation

PROFESSIONAL STAFF:	4 full time (ft), 23 part time (pt)
	Psychologist 2 ft, 2 pt
	Social worker 1 ft
	Coordinator/social worker 1 ft
	Teacher-clinician 5 pt
	Child care clinician 5 pt
	Supervisor 2 pt
	Psychiatrist 2 pt
	Psycho-linguistic clinician 7 pt
SERVICES AND TREATMENT PROVIDED:	
	Mental health program Educational psychotherapy
	Play therapy Supportive consultation services
	Psychotherapy Special research project
	Pharmacological therapy Play therapy
	Clinical classroom Joint education and mental health program
TRAINING PROVIDED:	Inservice: to clinicians
FUNDING SOURCE:	Various foundation grants
SPECIAL NEEDS:	Develop outpatient mental health program; funding; staff

Public School 47 School for the Deaf

Year established: 1973

225 East 23rd St.
New York, New York 10010
(212) 481-0300
Delores Doheny, coordinator

CHILDREN SERVED:	30 full time age range 0 to 21
TYPE OF FACILITY:	Day school, publicly supported, for multiply handicapped Deaf children only Primary, elementary, secondary (to 9th grade)
PROGRAM DESIGN:	Self-contained classes
PROFESSIONAL STAFF:	8 full time (ft), 2 part time (pt)
	Teacher 4 ft
	Educational assistant 4 ft
	Psychological service worker 2 pt
SERVICES AND TREATMENT PROVIDED:	
	Structured classroom curriculum
	Behavior modification
	Total communication
	Parent instruction in sign language
TRAINING PROVIDED:	Inservice: New York University Deafness Research and Training Center courses in emotional disturbance to licensed teachers of the deaf; NYU/DRTC student counselors and student teacher training
FUNDING SOURCE:	General school budget
SPECIAL NEEDS:	Increased medical, psychological, social work, guidance services; increased number of students participating in the program

New York School for the Deaf

555 Knollwood Road
White Plains, New York 10603

(914) 949-7310

Dr. David Spidal, principal

Year established: 1975

CHILDREN SERVED: 15 full time
age range 8 to 17

TYPE OF FACILITY: Residential, publicly supported
Deaf children only
Primary, elementary, secondary

PROGRAM DESIGN: Self-contained classes

PROFESSIONAL STAFF: 6 full time (ft), 6 part time (pt)

Teacher	3 ft
Teacher aide	3 ft
Psychologist	1 pt
Audiologist	1 pt
Social worker	1 pt
Consulting psychiatrist	3 pt

SERVICES AND TREATMENT PROVIDED:

Slower pace individualized curricula
Psycho-social emphasis
Direct therapy special project: younger group three times weekly, older group weekly
Special therapeutic intervention
Health services

TRAINING PROVIDED: *Inservice:* consultant to staff

FUNDING SOURCE: New York Department of Education; P.L. 89-313, Title I

SPECIAL NEEDS: Better physical facilities; better trained staff; experience

Institute of Logopedics

2400 Jardine
Wichita, Kansas

(316) 262-8271

Claretta Richardson, coordinator

Year established: 1969

CHILDREN SERVED: 15 full time
age range 5 to 7

TYPE OF FACILITY: Day and residential, privately supported, for multiply handicapped
Both deaf and hearing children
Primary, elementary

PROGRAM DESIGN: Self-contained classes, total milieu

PROFESSIONAL STAFF: 5 full time (ft), 4 part time (pt)

Teacher	2 ft
Speech clinician	2 ft
Aide	1 ft
Psychiatrist	1 pt
Audiologist	1 pt
Pediatrician	1 pt
Neurologist	1 pt
Individual program coordinator for each student	

SERVICES AND TREATMENT PROVIDED:

Individual total communication therapy daily	Art
Classroom total communication	Music
Residential living 1:1, 2:1, 3:1	Recreation
Individual program	Eclectic approach to intervention.
Direct behavioral intervention	Referral agency to severely maladjusted
Physical education	

TRAINING PROVIDED:

Inservice: workshop, films, total communication training
Outservice: interaction with other facilities, practicum experience for university students

FUNDING SOURCE:

Third-party funding

SPECIAL NEEDS:

More staff trained in total communication; more psychiatric monitoring of behavior problems; more systematic programing; placement for children 18 and over

Houston Independent School District**Year established: 1974**

Regional Day School Program for the Deaf

3830 Richmond

Houston, Texas 77027

(713) 623-5162

Kay Harston, director

CHILDREN SERVED:

13 full time
 age range 8 to 12

TYPE OF FACILITY:

Day school, publicly supported
 Deaf children only
 Primary, elementary, secondary

PROGRAM DESIGN:

Self-contained classes, resource room, total milieu, crisis intervention

PROFESSIONAL STAFF:

12 full time (ft), 5 part time (pt)

Teacher	3 ft
Aide	6 ft
Resource room teacher	1 ft
Coordinator	1 ft
Helping (crisis) teacher	1 ft
Administrator	1 pt
Social worker	1 pt
Psychologist	1 pt
Supervisor	1 pt
Nurse	1 pt

SERVICES AND TREATMENT PROVIDED:

Engineered classrooms: younger groups, older elementary
 Level II classroom: self-contained, small group work
 Reintegrate emotionally disturbed children into class with four model pupils
 Helping teacher: crisis intervention and supportive tutoring
 Resource rooms: 1:1 communication skills, individual work
 Home intervention: parents on call, behavior checklists

TRAINING PROVIDED:

Inservice: total communication, play and child development, continuous programs

FUNDING SOURCE:

P.L. 89-313

SPECIAL NEEDS:

Money for program development; part-time psychiatric consultant services

Directory Part B: Programs for Multiply Handicapped

**Baltimore City Special Project
for Severely/Profoundly Multiply
Handicapped Hearing Impaired Children**

Year established: 1975

School #36, 1919 North Broadway
Baltimore, Maryland 21213

(301) 396-9634

Dorothy Colman, coordinator

- CHILDREN SERVED:** 3 full time
age range 3.5 to 11
- TYPE OF FACILITY:** Day school, publicly supported, for multiply handicapped
Deaf children only
Primary, elementary
- PROGRAM DESIGN:** Resource room, total milieu
- PROFESSIONAL STAFF:** 5 full time (ft), 4 part time (pt)
- | | |
|----------------------------------|------|
| Teacher of the deaf | 1 ft |
| Speech pathologist | 1 ft |
| Audiologist | 1 ft |
| Parent trainer | 1 ft |
| Teacher aide | 1 ft |
| Behavior modification consultant | 1 pt |
| Visual disorders consultant | 1 pt |
| Occupational therapy consultant | 1 pt |
| Physical therapy consultant | 1 pt |
- SERVICES AND TREATMENT PROVIDED:**
- Diagnostic-prescriptive services
 - Educational therapy
 - Parent-Liaison program: weekly for home behavior intervention
 - Parent meetings
 - Support services to regular schools when students return
 - Itinerant resource person in regular schools daily
- TRAINING PROVIDED:** Inservice: site visits, staffing
- FUNDING SOURCE:** Federal, Bureau of Education for the Handicapped
- SPECIAL NEEDS:** More trained staff; accurate diagnosis and evaluation; more program development; better teacher:
pupil ratio 1:3

Elwyn Institute
 Elwyn, Pennsylvania 19063
 (215) 566-8800
 Paul Richardson, director

Year established: 1966

CHILDREN SERVED: 33 full time
 age range 3 to 22

TYPE OF FACILITY: Day and residential, privately supported, for multiply handicapped
 Both deaf and hearing children
 Primary, elementary, secondary

PROGRAM DESIGN: Self-contained classes, evaluation

PROFESSIONAL STAFF: 10 full time (ft), 7 part time (pt)

Teacher of the deaf	6 ft
Paraprofessional dormitory staff	4 ft
Vocational staff	1 pt
Psychiatrist	1 pt
Social worker	1 pt
Psychologist	1 pt
Medical personnel	1 pt
Occupational therapist	1 pt
Physical therapist	1 pt

SERVICES AND TREATMENT PROVIDED:

Diagnostic-prescriptive intervention	Psychiatric therapy as necessary
Individual educational program	Psychological counseling as necessary
Individual communication program	Occupational therapy
Individual vocational program	Physical therapy
Parent conferences	Referral agency

TRAINING PROVIDED: *Inservice:* manual communication, dormitory certification
Outservice: manual communication for parents, communication information to parents

FUNDING SOURCE: State and local districts

SPECIAL NEEDS: Specially trained staff to work with multiply handicapped deaf; prevocational and vocationally trained personnel; vocational training supervisor

Bethany Hill School

89 Bethany Road
Farmingham, Massachusetts 01701

(617) 879-0971

Sister Mary Carl, director

Year established: 1972

- CHILDREN SERVED:** 10 full time
age range 3.5 to 8
- TYPE OF FACILITY:** Day school, privately supported, for multiply handicapped
Both deaf and hearing children
Primary, elementary, secondary
- PROGRAM DESIGN:** Self-contained classes
- PROFESSIONAL STAFF:** 4 full time (ft), 9 part time (pt)
- | | |
|---|------|
| Teacher of the deaf | 4 ft |
| (each specializes in emotional disturbance, learning disabilities, or mental retardation) | |
| Consulting psychologist | 1 pt |
| Social worker | 4 pt |
| Consulting social worker | 1 pt |
| Medical doctor | 1 pt |
| Psychiatrist | 1 pt |
| Neurologist | 1 pt |
- SERVICES AND TREATMENT PROVIDED:**
- Diagnostic-prescriptive educational program
 - Individualized educational planning
 - Interest/ability related program
 - Parent support program
 - Total communication
 - Foster homes
 - Pooled specialized services
- TRAINING PROVIDED:** *Outservice:* total communication to parents
- FUNDING SOURCE:** PL-750 State law Ch. 766
- SPECIAL NEEDS:** Additional home care, additional medical services, perceptual-motor school materials

Program for Hearing Impaired

BOCES

Dutch Broadway School
Elmst, New York 11003

(516) 354-3113

Naomi Kunken, coordinator

Year established: 1971

- CHILDREN SERVED:** 11 full time
age range 10 to 18
- TYPE OF FACILITY:** Day school, publicly supported, for multiply handicapped
Both deaf and hearing children
Elementary, secondary
- PROGRAM DESIGN:** Self-contained classes

PROFESSIONAL STAFF: 3 full time (ft), 2 part time (pt)

Teacher	2 ft
Speech teacher	1 ft
Psychologist	1 pt
Curriculum teacher	1 pt

SERVICES AND TREATMENT PROVIDED:

Guidance
 Psychological services
 Speech
 Academic instruction
 Total communication
 Occupational education
 Language development

TRAINING PROVIDED: None reported

FUNDING SOURCE: Local districts

SPECIAL NEEDS: Occupational placement

North Carolina School for the Deaf

Year established: 1973

Rutherford Road
 Morgantown, North Carolina 28655
 (704) 433-2938
 Marilyn Williams, coordinator

CHILDREN SERVED: 10 full time
 age range 8 to 20

TYPE OF FACILITY: Residential, publicly supported, special program for multiply handicapped
 Deaf children only
 Primary, elementary, secondary

PROGRAM DESIGN: Self-contained classes

PROFESSIONAL STAFF: 4 full time (ft), 4 part time (pt)

Teacher	1 ft
Supervising teacher	1 ft
Coordinator	1 ft
Counselor	1 ft
Consulting psychologist	1 pt
Teacher aide	3 pt

SERVICES AND TREATMENT PROVIDED:

Behavioral and educational services in classroom and dormitory; individual programing for academic, vocational, and emotional needs

TRAINING PROVIDED: Inservice: psychological consultation

FUNDING SOURCE: Title I ESEA

SPECIAL NEEDS: Vocational education for severely impaired, postschool placement

Colorado School for Deaf and Blind

Kiowa and Institute Streets
Colorado Springs, Colorado 80903

(307) 636-5186

Norman Allen, director

Year established: 1972

CHILDREN SERVED: 6 full time
age range 8 to 16

TYPE OF FACILITY: Residential, publicly supported, for multiply handicapped
Both deaf and hearing children
Primary, elementary, secondary

PROGRAM DESIGN: Self-contained classes, total milieu, evaluation

PROFESSIONAL STAFF: 3 full time (ft), 3 part time (pt)

Principal	1 ft
Supervisors	2 ft
Psychologist	1 pt
Child care evaluation center counselor	1 pt
Psychometrist	1 pt

SERVICES AND TREATMENT PROVIDED:

Behavior management program	Daily living skills
Individualized prescriptive program	Child care evaluation
Academic classroom 1:4	Treatment center
Residential and Academic facility in one bldg.	Play therapy
Prevocational program	Counseling

TRAINING PROVIDED: None reported

FUNDING SOURCE: P.L. 89-313, Title I

SPECIAL NEEDS: Trained staff to accommodate more severely disturbed children

California School for the Deaf

2601 Warring St.
Berkeley, California

(415) 845-4629

Les Rudy, coordinator

Year established: 1975

CHILDREN SERVED: 11 full time
age range 8 to 17

TYPE OF FACILITY: Residential, publicly supported special program for multiply handicapped
Deaf children only
Primary, elementary, secondary

PROGRAM DESIGN: Self-contained classes, total milieu

PROFESSIONAL STAFF: 7 full time (ft), 2 part time (pt)

Teacher	2 ft
Principal	1 ft
Dormitory counselors	3 ft
Supervising instructional counselor	1 ft
Consulting psychologist	1 pt
Consulting psychometrist	1 pt

SERVICES AND TREATMENT PROVIDED:

Individualized program, classroom plus dormitory
 Language, reading, and math skills
 Counseling 1:1, limited basis
 Projective testing
 Integration and regular vocational program

TRAINING PROVIDED:

Inservice: behavior modification

FUNDING SOURCE:

P.L. 89-313, Title I

SPECIAL NEEDS:

Increased staff: teachers, counselor, part-time nurse, physical therapist, occupational therapist, increased classrooms

California School for the Deaf

3044 Horace St.
 Riverside, California 92506

(714) 683-8140

Dr. Robert Lennan, Assistant Superintendent

Year established: 1969

CHILDREN SERVED:

35 full time
 age range 5 to 19

TYPE OF FACILITY:

Residential, publicly supported, for multiple handicapped
 Deaf children only
 Primary, elementary, secondary

PROGRAM DESIGN:

Self-contained classes, total milieu

PROFESSIONAL STAFF:

21 full time (ft)
 Assistant superintendent 1 ft
 Principal 1 ft
 Academic teacher 8 ft
 Physical education teacher 1 ft
 Supervising instructional counselor 1 ft
 Dormitory staff 8 ft
 Psycho-educational consultant 1 ft

SERVICES AND TREATMENT PROVIDED:

Educational program for multiply handicapped deaf
 Prevocational work experience program
 Behavior modification
 Modeling

TRAINING PROVIDED:

Inservice: behavior modification principles; program individualization based on criterion-referenced curricula

FUNDING SOURCE:

California State Department of Education

SPECIAL NEEDS:

Increased community work placement; halfway house; sheltered workshop with staff qualified to work with deaf.

Part III
FEDERAL PERSPECTIVES

THE PERSPECTIVE OF THE REHABILITATION SERVICES ADMINISTRATION

Boyce Williams, LL.D.

Dr. Williams is Director of the Office of Communicative Disorders, which reports directly to the U.S. Commissioner of Rehabilitation.

I am involved with the State-Federal program of vocational rehabilitation, and our action point or our horizon is with the State vocational rehabilitation agencies. That is where services are developed and delivered.

We have for over 25 years been very concerned about the mental health needs of deaf people. In fact, through our research and demonstration program, funded out of the Federal office, we began that kind of work in New York, as most of you probably know. The research and demonstration capabilities for contacting a large population are not very effective. They are fact-finding and information development. The service aspects must happen in the States and local communities and, with that in mind, we have encouraged our State agencies to work with mentally and emotionally disturbed deaf people in and out of hospitals.

Our reporting system does not permit us to know how many individuals of that description are being served at any given time or even through 1 year, but we do know that more and more and more States are becoming interested and are trying to establish useful programs. At

last count we had more than 18 States with programs that were more than a dream, that were really in practice.

We have a manpower problem, but our capability these past 8 years to do something constructive about that has been very limited; but again, we can hope. With your help and a lot of push from the various centers and the State agencies we can do a better job of getting people ready for delivering mental health services to the deaf population.

We know that we must use many resources that have not had much experience in the very complex area of mental health. The hospitals themselves are prime resources but people often don't like the concept of a hospital. We must develop other areas for service. We have established clinics of one kind or another that have been very successful. We are using hearing and speech associations. We must look for more outlets that are fully acceptable to our deaf population so that people will go for the help that they need, make themselves known, and seek out that very important service.

THE IMPACT OF PUBLIC LAW 94-142

Thomas Behrens, Ph.D.

Dr. Behrens is with the Division of Personnel Preparation of the Bureau of Education for the Handicapped, and has worked as an educator and educational administrator with deaf children.

Rather than discussing the Bureau and its present services, I would like to point out one of the most important things which has happened in the educational system in our country. This is Public Law 94-142, which finally achieves the long worked-for goal—that every handicapped child in this country has the right to an education.

What does 94-142 do?

It is a response of the Congress to a State appeal to gain support for all the educational demands which were ordered by the courts. It is no longer "If you want to do it, you can do it." It is a law, which authorizes that by 1978 all children in the age range of 3 to 18 have to have an appropriate education and, by 1981, all children in the age range of 3 to 21 have the right to an appropriate education. I think Congress means it seriously, in that the authorization — be careful, this is the authorization, not the appropriation — for fiscal year 1980 is \$1.2 billion. By 1982, \$3.16 billion are authorized. Please, let's not kid ourselves; I don't think we will get the appropriations. But the mere fact that the Congress and the President were talking in such high figures in authorization levels should show to us in the field that there is no longer a reason to say we cannot do it or we don't have enough funds.

Now, what are the priorities? The first priority is the unserved population of handicapped children. We estimate at the present time that over 40 percent of handicapped children and youth in this country are not receiving any education. This is the first priority. The second priority is the inadequately served child and

the child who is severely handicapped, and I think that it is very appropriate to talk at this workshop about that. With the new Education of the Handicapped Act, we are very hopeful to be a partner in your new challenge to achieve a breakthrough for the better health and better education of deaf children who are in fact in need of service.

Now, just a few more points: The responsibility for the education of a handicapped child, through this new law, lies with one person and that person is the head of the State school system. In other words, the law says there is one person responsible in each State and that person is the head of education. This person can delegate authority to other agencies to provide this service, but the final responsibility finally has been determined. All of us know that this will cause some problems, but this will put an end to the shifting of severely handicapped children from one agency to another, so that these children have never received an education by the time they become adults.

Another very important issue is that children have the right to receive their education in the least restrictive environment. This, very frankly, is going to put a very big challenge on our professional knowledge. Up to now we always have been thinking in terms of centers or regionalized things, but the law is watching us on how are we going to do that. So I hope that as a beginning of this workshop we will address ourselves to new opportunities for children who are in need of mental health services and education, so that we can provide those in a real human and loving, least restrictive environment.

BIOMETRIC CONSIDERATIONS IN THE PLANNING OF MENTAL HEALTH SERVICES

Morton Kramer, Sc.D.

Dr. Kramer is Director of the Division of Biometry and Epidemiology of NIMH.

I welcome the opportunity of speaking to this group, which is the first opportunity I have had to get involved in the field of both deafness and mental health. I want to show you why it is important to understand some population trends that will be occurring in the United States within the next decade. But before I go on to that I would just like to cover briefly the kinds of activity we carry out in our Division of Biometry and Epidemiology.

We are a quantitatively oriented division, that is, we deal with measurement, numbers, and the techniques used to collect, process, and analyze those numbers. We hope to turn the numbers into meaningful rates, ratios, and other kinds of indices that can be used to draw important inferences. We are organized into the following branches: demography and social studies, survey and reports, applied biometric research, statistical programs development, the center for epidemiologic studies, and the theoretical statistics and mathematics branch. It would take quite a while to illustrate exactly how we operate in the work that we do. For now, let me say that we are overwhelmed with demands to be of assistance to individuals who are trying to gather data for planning and evaluation, along with those who are trying to develop designs for experimental studies, and also providing certain background data that are needed for planning of national health insurance, if and when that ever becomes a reality. In the event that national health insurance becomes a reality, it is important to produce data that demonstrate the need to provide coverage for persons with mental disorders. I would presume persons with deafness would be covered up to a point. I do not know what would be involved in terms of long-term

care for the deaf and the deaf mentally ill.

I would like to illustrate a few points that are relevant to the care of the mentally ill in the United States. As you will see, they have extraordinary relevance to the need for services for those among the mentally ill who may need special care because they are deaf or have hearing impairments of one kind or another. An extraordinary change has taken place in the locus where mental health services are delivered. In 1955 about half of all mental health services provided to residents of the United States were provided in the State and county mental hospitals, and only about 23 percent of the services were provided in outpatient services. As of 1973, the volume of services rendered has increased three-fold, from 1,700,000 patient care episodes up to 5,200,000. At the same time, the proportion of services rendered by the State and county mental hospitals dropped from one-half to about 12 percent. Outpatient services have increased enormously, and the community mental health centers added another dimension to that. Essentially over 70 percent of all services are now provided either through outpatient clinics or through the community mental health centers. This is only part of the picture, because we know that a large volume of mental health services must be provided in one way or another by the nonpsychiatric physicians and by psychiatrists in private practice, but I will not go into that issue here because it is a complex one.

Another aspect of what has been happening is this: A striking change has taken place in the population under age 20 in the institutional population of the United States. The institutional population consists of individuals in mental institutions, homes for the aged and

dependent, correctional institutions, training schools for juvenile delinquents, homes and schools for the mentally handicapped, tuberculosis hospitals, and all other similar institutions. First, the mental institution population under age 20 has increased. Correctional institutions and training schools for juvenile delinquents account for only a small proportion of the white males, but the figures are six times higher for the nonwhite males under age 20. I can't go into this in detail, but there is a striking change in the kinds of institutional population we now have, and particularly since the mental institutions have dropped in size.

The drop in the mental institutions has taken place especially in the population age 65 and over, but, as that has happened, the homes for the aged and dependent have grown remarkably, particularly for males. The picture is extraordinarily different for nonwhite males. This gets to be important, because as I was reviewing the volume on the prevalence of deafness in the United States, it emphasized that it concentrated on the noninstitutional population. But the institutional population is enormous for certain age groups and racial groups. For example, among nonwhite males in the age group 20-24, about 4.6 percent as of 1970 were in an institution, with more than 80 percent in correctional institutions. As another example, there has been a very rapid increase of white females in the homes for aged and dependent; as the mental institution population dropped, this figure went up enormously. There has been, also, an aging trend in the schools for the mentally handicapped, while the correctional population of white females is very small. For nonwhite females the patterns are similar but less drastic. The drop in the mental institution group has not been as marked, and the group in homes for aged and dependent have increased but not as rapidly as for the white females. There is also a significant nonwhite female correctional population.

Now, why is all this important? In the work that one does in this field, one should be aware of population shifts that are taking place within the United States. There is a lot of talk about zero population growth, but I don't believe I will live to see zero population growth, which will take place sometime after the year 2000 —

maybe I'll be lucky or unlucky enough to survive, who knows? — but anyway, between 1970 and 1985 striking changes will be taking place in the age distribution of the United States. For example, between 1970 and 1985 there will be about a 10 percent drop in the white population under 18, because of the drop in the birth rate in the white population. In the nonwhite group under 18, there will be an increase of about 8 percent. The nonwhite birth rate is dropping too, but is still higher than that for the white population. For the 18 to 24 age group, there will be a 40 percent increase in the nonwhite population, compared to an 18 percent increase in the white group. In the 25 to 34 age group, there is an extraordinary 90 percent increase coming in the nonwhite population and about 60 percent in the white population. For the 35 to 44 age group there is, on the other hand, about a 40 percent drop, because of the low birth rate that occurred between 1920 and 1940. But for the group age 65 and over, there is a remarkable increase.

Why is this important? Consider, for example, that the prevalence rate for significant bilateral deafness is 17 percent in the age group 65 and over. Well, you will be having about a 50 percent increase in that population group in the next 10 years or so. Thus, even if the rate of hearing loss remains the same, 50 percent more people will have an impairment in that age group. You are getting involved in some very high-risk groups here. Even though the rate of deafness may be lower for the 25 to 34 age group, there will be such an extraordinary growth in that population group that you will have many more deaf persons. The point is that these population shifts have important implications for programs for mental health services, for the correctional institutions, for the programs for deaf people. Nobody, so far as I know, is paying much attention to these truly extraordinary population shifts which are taking place.

At the same time that the need for research data of this kind increase greatly, the budgets of the NIMH for research have been dropping precipitously. The President's Biomedical Research Panel urged that this trend be reversed. Whether the Congress will do it, only the future will tell.

RESEARCH PROGRAMS WITHIN THE NATIONAL INSTITUTE OF MENTAL HEALTH

Morris Parloff, Ph.D.

Dr. Parloff is Chief of the Psychotherapy and Behavioral Intervention Section, Clinical Research Branch, in the Division of Extramural Research of NIMH.

I am pleased to be here to act as one of your guides to the complex NIMH organizational and functional maze. I think it is important that you understand that the NIMH is organized into three major units: services, manpower and training, and research. Some people would view this as an indication that the NIMH has enough gall to be divided into three parts.

The point that I am going to emphasize today is the area of research. While I was introduced as the chief of one section, I wish to speak about the overall Division of Extramural Research Programs. It is this area that represents the major research function. There are four branches in the Extramural Research Program, and I will talk a bit about each of these: the Clinical Research Branch, the Applied Research Branch, Psychopharmacology, and Behavioral Sciences.

The Clinical Research Branch attempts to implement the NIMH mission, which is to increase knowledge regarding mental illnesses and emotional disorders in order to understand more about the etiologies of mental disorders, their diagnosis and treatment, and ultimately, their prevention. The Clinical Research Branch focuses primarily on mental disorders which are of the classical type, namely, schizophrenia, depression, neuroses, psychosomatic disorders, and various other character disorders and personality disorders. The major emphases there are to understand and to classify pathology. We also attempt to develop new instruments for measurement and to study the genetics, the biological, and the neurophysiological factors which affect the etiology or pathology. As has already been mentioned, we have a great concern about the psychotherapy of these disorders, and our effort

is to assess the processes of change and the effectiveness of change. There also are special emphases on the two major areas of depression and schizophrenia. More recently, with Dr. Beatrice Hamburg joining our staff, we have been able to expand our horizons a bit and to include studies of childhood and adolescence. At the moment, I think the emphasis will be on the understanding and classification of psychopathology, or what we mean by psychopathology in that area of childhood and adolescence.

The branch I would like to talk about next is the Applied Research Branch. I'm always hesitant about this because the question of our organization is a very interesting one. Whenever we are talking about organization, it is talking about something that has been constructed over a period of time. The NIMH has had a long enough period of operation to have been wisely constructed at one point for its purposes, and then to have undergone various pressures, tugs, and new wisdoms, and so we have units that look rather odd in terms of their function and specialized mission. For example, this unit is concerned with social problems. However, it does not deal with crime and delinquency, urban or minority problems, because these have been taken out for special attention in special centers which you might hear about. It is limited to concerns about family problems, marital relationships, the effects of divorce, problems of sexual adjustment, changing sexual roles, etc. although the section on psychotherapy is concerned with psychotherapy, the sex therapies are somehow delegated to this particular organization, so, as you can see, the organizations are not all that neat, but that need not concern you

if you are interested in submitting research projects; you need only know what the overall NIMH program is about. The applied research group also concerns itself with problems of childhood in the sense of intellectual stimulation and cultural enrichment and some problems of adolescence and early adulthood. So there is considerable overlap.

The Psychopharmacology Research Branch is rather crisp and clear. Its job, as delegated by Congress, is to study ways in which drugs influence thought, mood, and behavior, and by drugs I mean the "good" drugs — the psychotropic drugs, and to evaluate the efficacy and safety of drug treatment.

Then the last group I want to talk about is the Behavioral Sciences Research Branch, which is the largest branch, and which has the largest scope. It concerns itself with basic research in psychology, biology, and sociocultural areas. It deals, for example, with personality and cognition; experimental psychology; neuropsychology, that is, the brain and behavior; the Social

Sciences Section, which concerns itself with anthropology, sociology, and social psychology.

Now in addition to these major groupings, we have two other sections which are hard to classify. One is called "Small Grants," a very active, large program which gives out small amounts of money, limited to about \$5,000 a year (or if there is something extraordinary you might get \$6,000 for 1 year). This is a very large scale operation to help people, who have pilot studies, initiate grants and it is very well used.

The last section concerns research scientists development. It is the program that is used by junior investigators to develop their careers, and it is also used by senior investigators who may be supported for as long as 15 years. Now I realize I have given you a great deal of material about the organization, and I expect there will be a number of questions about what this all means. And I would appreciate the questions either being directed to me or to Dr. Hamburg who will be here for the rest of the day.

MANPOWER AND TRAINING PROGRAMS OF THE NATIONAL INSTITUTE OF MENTAL HEALTH

Ralph Simon, Ph.D.

Dr. Simon is Chief of the Experimental and Special Projects Branch, Division of Manpower and Training, NIMH.

It's always a pleasure getting into a relatively new area, since my major responsibilities at the National Institute of Mental Health and the Division of Manpower and Training Programs have been dealing with projects that are referred to as new, unique, and innovative. I'd like to get back to that in a moment.

First, I'd like to give you some overview of what the Division of Manpower and Training Programs is all about. I'm not going to give you detailed information about each one of these programs, because somebody has done a good job in assembling some materials for you in one of these packets. I imagine it was Dr. Robinson and his staff. Curiously, the program that I represent is not in here, as far as the guidelines are concerned, so I'll say a few words about them.

The Division of Manpower and Training Programs was started early on when the National Institute of Mental Health was established almost 30 years ago. It started out as a major resource in the training of mental health manpower in the disciplines, so that the focus was on the areas of psychiatry, social work, nursing, and psychology. Subsequently, over the years, its mission has expanded so that it has added three other programs: The Continuing Education Branch; the Paraprofessional Manpower Development Branch; and the Experimental and Special Projects Branch, which I represent. It's curious that, with representatives of Federal programs here, no one has specifically mentioned money, perhaps because it's such a sad subject, but I should point out that we are in the process now of spending some \$63 million for manpower and training programs. Before you get your hopes up about the availability of large

sums of money, you might be interested in knowing that last year we funded at a level of \$72 million. The \$63 million is actually a Congressional appropriation overriding the President's budget of \$45 million for this year. The President's budget for us for next year is \$30 million, so we are at the mercy of the Congress with regard to our existence in the future. There is a very definite attempt on the part of the administration to phase out mental health training programs.

There is a very wide diversity in these programs and, in thinking about this meeting, I was asking myself whether any of these programs are relevant to the interests of the group here, and in effect all of them really are. I believe, though, that as I have uncovered as being active in this area is one in which Dr. Schlesinger has participated in one of the university programs that has a psychiatry program.

I thought I had reached a low with regard to activity in programing about 2 weeks ago when I attended a meeting on aging. Somebody referred to a publication that we put out called "Explorations in Mental Health," and cited the fact that there was only one program in aging in there; we subsequently have added a few more. If someone were to go through that booklet now and look for anything that has to do with programing for the deaf, I am afraid we would reach a new low point, in that there is no activity in this area.

Our programs take some pride in charting new areas. We were involved, for instance, in development of programs for the training of Indian medicine men some 8 years ago. We are currently funding a program to train "expiritists," or spiritists, in Puerto Rico; these are

essentially mediums who have a relationship to the population. We get interesting, unusual kinds of requests for things such as horticultural therapy. One which we had a short time ago dealt with bluegrass music as a form of therapy in an urban community. We're not all that traditional and are very much attuned and open to a wide variety of training activities that point a new direction and deal with new populations.

I should point out that the NIMH Division of Manpower and Training Programs has certain priorities that will probably be modified only slightly in the year to come. One is the development of manpower needs for mental health service delivery. A second is one that I would think would be most relevant to this group, and that is to provide services to underserved populations. Now this is a very broad category; it often deals with geographic distribution but it also deals with groups that do not get served. I alluded previously to groups such as Indians, but there are also other groups that have special disabilities. As an aside I might add that we will be funding two projects in the area of human sexuality this year for physically disabled persons, mostly individuals who have neurological disorders.

The point I'm trying to get across is the breadth and scope of the possibilities that are available depending upon the creativity of whatever persons might be applying for grants. The other priorities that are listed are mental health and minority groups and women, child mental health, and aging. Those which will more than likely be added this year have to do with primary care, persons trained in primary care, deinstitutionalization, and community-based services. One other activity that I think is relevant to this group has to do with Federal-State relations or programing at a State level.

While thinking about some of the issues that would be concerned with potential programing and funding, I was trying to identify ways to go about this type of thing and realized there are

certain kinds of questions that would need to be raised. I hope that in the course of this conference certain of these issues will be identified. One is, what is the training capability in this particular area at this time? What are the resources? Are there people and staff of sufficient numbers and quality to provide training? Are facilities available? Are there sanctions within programs to train relevantly for this particular population? I think one of the earlier speakers raised the question too about what level of training there should be. Should you train *de novo*, should you train professionals right from the start, or is this more likely to be an inservice, continuing education type of program? I must confess my lack of knowledge of this field. What is a description of what a program would look like? What are the skills, knowledges, attitudes that would be required in such programmatic ventures? And to round out the issue on levels of training, is this a postprofessional, a professional, a preprofessional, an indigenous nonprofessional type approach? Is it all or some combination of these that is appropriate for this kind of field? I think these are some other issues that you will have to address.

The final question is (I think I have a general answer to this), should the training be at an institutional, local, regional, or State level? Where is the most effective clout developed in terms of the kinds of capabilities, in terms of the possibilities for implementation? These are certainly not all of the questions, not all of the issues, but they are the kind that would occur to someone like myself representing a Federal program that would be involved in potential funding activities.

One final piece of information, should anybody be interested: I think it would be advisable to be in touch with us, since we will be coming out with new guidelines, probably in a month or so, and we would likely have a deadline, if we are continued in existence, somewhere around September 1 or September 15.

RESOURCES AVAILABLE FOR SUPPORT OF MENTAL HEALTH SERVICE PROGRAMS

Judith Turner

Ms. Turner is Chief of Community Support and Rehabilitation Systems, Community Mental Health Services Support Branch, Division of Mental Health Services, NIMH.

I will briefly describe the major ways in which the Division of Mental Health Services makes resources available to States and localities for support of service programs. Probably most of you are familiar with the Community Mental Health Centers Programs which, as you perhaps know, was amended last July. We've had new legislation, Public Law 94-63, which was passed over the President's veto and which demonstrates a commitment on the part of the Congress to develop a nationwide network of community mental health services.

There are some interesting features of the new legislation which are worth mentioning. Perhaps most of you know that the original community mental health center legislation specified that community mental health centers must provide five essential services. This included inpatient, outpatient, partial hospitalization, emergency services, and consultation and education. There were also some optional services that could be provided. The new legislation expands the responsibilities of federally funded community mental health centers and gives community mental health centers 2 years to convert to provision of 12 essential services.

The new services that are required include programs of specialized services for children, programs of specialized services for the elderly, and three new services that relate specifically to the transition from hospital-based to community-based care. These three services are: Assistance to the courts in screening residents of the center's catchment area being considered for referral to a State mental health facility; a program of transitional halfway house services for residents of the catchment area who have been

discharged from mental health facilities or who are being considered for referral and might better be served in a halfway house or some alternative community kind of program; and followup care for people discharged from mental health facilities. Just parenthetically I'll mention that NIMH is interpreting the requirements for a program of transitional halfway house services to include a wide variety and spectrum of locations, for example, cooperative apartment programs, foster care, and other settings in which mental health and rehabilitative services can be made available. Any of these could be included under a program of transitional halfway house services.

Two other services which are required of community mental health centers are special programs for alcoholism and drug abuse. These are optional in the sense that they need not be required if there is documentation that the needs are being met by other agencies within the catchment area.

One thing that would perhaps be of special interest to this group would be the consultation and education function of a community mental health center, which is intended to supplement the direct services of the center and provide a range of consultation and education to various agencies within the catchment area which are involved in serving mental health-related needs. This could, for example, include schools, courts, churches, and a wide variety of types of agencies. There might be some ways in which community mental health centers could assist with meeting the special needs of emotionally disturbed deaf people under the consultation and education function. We've just had the first round of applications under the new legislation and the appro-

priations have been much less than the authorizations, but the program is going on and I suspect we will be hearing more about the efforts of community mental health centers to meet the special needs of emotionally disturbed deaf people in the future.

A second activity within our division, and this relates to Dr. Parloff's comments about organization, is that we have within the Division of Mental Health Services (DMHS) a research function. Within the DMHS there is a program for support of applied research which relates to the development of improved methods for delivery of services. At the moment this program, like many others, is suffering from a large number of applications and a shortage of money, but the program is there and possibly in the future this might be an avenue for the support of research related to services to the emotionally disturbed deaf.

Another program within the Division which undoubtedly is known to many of you is the Hospital Improvement Program, which provides grants of up to \$100,000 per year to State hos-

pitals. When this program was originally developed, the focus of the program was on improving services and the quality of care within State hospitals, and, gradually, as we began to see the decline in hospital populations and the need for strengthening relationships between hospitals and communities, our priorities have shifted so that at present our primary focus of the Hospital Improvement Program is on building linkages between hospital-based and community-based care. This program is scheduled for phase-out by the administration, and this year there is very little money available for new starts.

A fourth program which may be of interest to this group is the Hospital Staff Development Program, which provides grants of up to \$25,000 per year to State hospitals or State mental health authorities to provide the type of training that is particularly needed to improve service delivery within that State. I've run out of time, and I think I have covered the essential materials. If there are questions I'd be happy to talk with you later in the day.

ADVOCACY FOR CHILDREN AND YOUTH IN THE NATIONAL INSTITUTE OF MENTAL HEALTH

Steven Hirsh, M.D.

Dr. Hirsh is Director of the Office of Children and Youth, NIMH.

First I think it is very important to point out what Dr. Robinson, Dr. Goulder, and the other people who have organized today's program are doing, because they are doing at least two things simultaneously. I've learned over the past several years that Luther is a gentle educator and in that context an intense advocate for the deaf. What he's doing this morning, besides bringing us here to share some information with you is the intense advocacy part, because as you have already picked up, very few of us know very much about the deaf or deaf programs, and he is simultaneously educating us as we are here to share some things with you. So I think we all owe him some gratitude for that. I think you're very clever in what you are doing, and it will have some kind of impact, though usually in the Federal system your sense of time has to be in the context of several years.

The few points I will make are as follows: first of all, it is worth making note of my position, or the position that I happen to be the first person to occupy. It is simply one point in a historical movement that began in this country at least at the end of the 19th century, and probably before, but it's most noticeable at a national level at the end of the 19th century, and that's the movement on behalf of optimizing, working toward the development of all children and youth, and behind that is the philosophy that children and youth do represent the major social and economic resource of any society. There have been various changes over time from the end of the 19th century, and all of you are aware that there have been a series of things called "White House Conferences" beginning in the days of Teddy Roosevelt. Gradually there has been increasing awareness at State and Federal levels that it is important to do some intelligent planning and thinking on behalf of

that part of our population from which we all come.

Most recently there have been a number of things that have happened at the Federal level, and, if they stay in existence, I would suggest that they are important changes. They include such things as the creation of an assistant directorship of the total NIMH for children and youth; this is the first time that such a position has been created. Almost simultaneously there was the creation of an advocacy group within the Alcohol, Drug Abuse, and Mental Health Administration for Children and Youth, and also at the same time there was the creation of an executive committee at the level of the Assistant Secretary for Health on behalf of child and maternal health. These positions, these changes, are extremely important in terms of planning, in terms of distribution of resources, and that's why I call them to your attention. A character such as myself at this point functions at all three levels simultaneously.

The second point I wanted to make in terms of any of the special groups in our society, the deaf, or the visually handicapped, or the mentally retarded, is that there may be some parallels in discomfort in terms of the mental health system. For the last decade we have had at the National Institute of Mental Health (NIMH) some serious problems with the mental retardation community. They did not, in general, want to be associated with us because of their point in the context of their advocacy, that mental health and mental illness are not the same as mental retardation. This is changing, fortunately, and I think we are just going back a little in time to accept our origins in the 1946 legislation. There a Federal role in mental health was created, not only to deal with psychopathology, with mental health problems, but also to en-

hance, referring to the comments of Thomas Goulder, the ability of the people of the United States to love and to work.

We talk a great deal about professionals, and we talk a great deal about education, and services for professionals, and we have heard some things about that today, and we have been very much directed toward that. I think all of us, though, are aware of the crises in the family structure and in the role of parents and guardians in this society, and the blurring of roles between the school system and the family. This is something also I think one must call to your attention.

Our role at the Federal level, I see not only as a funding one, but also as a convening and synthesizing role. It is a role where we have to insist that research is critically important, but is not enough; that training of professional manpower at different levels is critically important but is not enough; and that we have to work with the population as a whole and work out different ways of communicating the information that we do have to the population. I include children in this, so that they can use this in a preventive fashion as well as in early interventive fashion, because there will never be enough health pro-

fessionals to go around if we think that they are the ones who are supposed to take care of us.

A final comment is just a very quick remark about NIMH. NIMH is a tiny part of the Federal system. It is complex, it consists of 10 Divisions. You saw an example of just some of them in terms of our research responsibilities in this country and abroad. It is rather astounding that even today, given the shrinking of our resources, 40 percent of the basic psychological research done in this country is done within our own laboratories at NIMH, some of which are here at Saint Elizabeths Hospital. But we're small, we're only about a \$400 million enterprise, of which a little over half goes to the community mental health center programs and to the support of Saint Elizabeths Hospital.

I think there is just an immense amount of information that would be worthwhile having, but we don't have time today. I can just hope that you have, with the help of the people who put this conference together, seen a few faces in this rather confusing morass called the Federal Government. We are here in our public servant role to answer questions that you can direct toward us, not only today, and please write to us if we can be of assistance.

NATIONAL PRIORITY ISSUES IN MENTAL HEALTH SERVICES

Thomas Plaut, Ph.D.

Dr. Plaut is Deputy Director of the National Institute of Mental Health.

I am not going to talk about the NIMH; I am not going to talk about the bureaucracy. I am just going to mention several issues in the area of mental health services which keep coming across our desks which are in the foreground for people in the Federal Government.

It is very clear that the last 20 years have been a very substantial reduction of the stigma attached to mental illness and to seeking help for emotional problems. There has been a reduction of the sense of shame, the sense of guilt, the sense of uneasiness attached to seeking help for emotional problems. Those of you who work in the area of the particular problems of the deaf mentally ill are aware of the two-fold stigma and the barriers which have to be overcome. Not only are there complex and emotionally charged public attitudes toward deafness but there are equally complex and emotionally charged attitudes toward mental illness. So we have made a lot of progress in the last 20 years in reducing the prejudice that surrounds acknowledging that one has an emotional problem and the sense of shame around seeking help for emotional difficulties, but we still have a long way to go.

We talk about returning the care of psychiatrically ill persons to the mainstream of where health and other services are provided. It is very clear that the return of the care of the emotionally upset patient to the mainstream of health care has proceeded and continues to proceed. I think it is now 6 or 7 years that we have had more psychiatric patients admitted to the wards, the specialized psychiatric wards of community-based general hospitals, rather than to the State and county mental hospitals. Now, lest I leave an erroneous impression, I am talking about admissions, about patient care episodes. If you look at days of patient care you will, of course, find that there are still many, many more days of patient care in the State and county mental

hospitals than in the local, general community-based hospitals.

We have heard a lot of discussion in recent years around national health insurance. National health insurance was anticipated as a reality certainly by 1972 or 1974, but we still don't have it. It's not going to be enacted this year or probably next year, but it will come about before very long. It is unclear whether it will come about incrementally, first for certain subgroups, say, children and mothers of young children, or only for low-income people, or whether it will be the whole thing at once. But I think we need to be cautious about thinking that national health insurance is going to solve the major problems that we have in relation to services for emotionally disturbed persons.

There is a lot of discussion going on regarding what kind of coverage for psychiatric services should be part of national health insurance proposals. Many people say that coverage for psychiatric care should be nondiscriminatory, that there should be the same coverage for psychiatric disorders that there is for physical illness. This is the equal coverage position, the position, essentially, of the American Psychological Association. There is a lot to be said for this position, but at the same time other people have suggested that such a position could lock the mental health field and those of us involved in the delivery of mental health services into certain kinds of services, certain kinds of requirements which set the field back. Let me be specific and concrete. Suppose that for general physical illness there is very generous and reasonable coverage for inpatient care, for hospitalization, and reasonable coverage for ambulatory outpatient care, but no coverage, or only very restricted coverage for intermediate care, partial hospitalization, day and night hospitals, and other kinds of services which the mental health

field has pioneered and developed. This would mean that if we stuck only with the position of equal coverage, we might end up with a financing system for physical conditions and for mental conditions that would set us back to the days when we only had inpatient care and ambulatory outpatient services and had no intermediate services at all. So that is one kind of issue we need to be aware of.

In addition, it is unlikely that national health insurance for physical conditions will emphasize preventive services. It may emphasize or pay for screening of one type or another, but preventive services that are directed at public education, that are like the services of the Community Mental Health Centers Program, namely, consultation and education services, what we refer to as indirect services, they are not going to be covered under national health insurance.

Then we face another dilemma that is very critical in the mental health field. Many of the men and women and families that we work with have a need for a broad range of social support services in addition to the psychiatric services, narrowly defined, which we provide. This includes social casework, but it also includes recreational services, rehabilitation services, vocational services, sometimes legal services, and foster placement services. Many of these support services are absolutely essential if we are going to get dividends or benefits from the specialized psychiatric services. Now, again, it is very unlikely that national health insurance will define these social support services as health services. So we may find ourselves seeing the disappearance or reduction of some of these support services because they cannot be financed as health services and this also could conceivably set us back in the mental health field.

I have said at times that it would be very unfortunate if we develop a national health insurance program which is not parallel, which does not have running alongside it some way of paying for these support services. Some people have even argued that national health insurance will probably be a failure the first time around unless it is paralleled by some sort of national social support insurance. We know in the mental health field, and I would say this is particularly the case when we are dealing with groups of persons who have double handicaps, double disabilities. These support services can often make the difference in whether a man or woman can be rehabilitated, whether they can return to their community and function independently. So this is a real dilemma.

Unfortunately, and this is a personal editorial comment, in this country we are still a long way from accepting the fact that people have a right to social support services. We are beginning to accept the fact that people have a right to health and medical care services. Generally, in the United States, social support and social services are publicly supported. Social support and social services are identified with public welfare, with people who are indigent. In Great Britain the public social services are viewed very differently, and a very broad part of the socioeconomic spectrum, people into the middle class, use the public social services that are available. There is a sliding scale, so you pay something for it if you can afford to.

I had the experience for the Ford Foundation of visiting some locally supported public services in Britain about 2 or 3 years ago. We had an opportunity to see the local "meals on wheels" program, which brought food, one warm meal a day to people who were homebound, to old people as well as younger people. It was very striking, the extent to which the program was provided not only to the very poor, but also to middle-class people who otherwise might not have been able to manage at home alone, and they paid something for it. The program was partly government financed and partly staffed with volunteers. I illustrate this to indicate that until we have different attitudes, different public support for tax-supported social support services, we are going to have some hard problems with how much can be solved by national health insurance.

Then there is another very complicated issue around national health insurance and that is whether we will use the financial leverage of national health insurance to do something about developing better systems — and I underline the word systems — for the delivery of mental health services; or whether we will see national health insurance simply as a way of removing financial barriers, of putting purchasing power into people's wallets. The experience we have had with Medicaid and with Medicare has been that these two governmental programs have removed some of the financial barriers I just described. But they probably have not improved the service delivery system. We still have hospitals that are unrelated or only loosely related to nursing homes. We have doctors who are unrelated to nursing homes and to hospitals. The financing methods of the Medicaid and Medicare programs have really not encouraged the development of comprehensive systems for

the delivery of health services. By this I mean systems which emphasize a range of services and continuity of care, some of the principles that underlie the whole concept of community mental health (I am talking here about a philosophy dealing with the delivery of mental health services and not about a particular Federal program).

There is a great deal of disagreement in the Congress and in medical and health care circles as to how one could use the tremendous power and dollar leverage of national health insurance to do something about the delivery system. We must get away from having two delivery systems, one for wealthy people and another one for people who are indigent or not as well off financially. There is a grave problem in this regard in relation to national health insurance because there probably will be a limit on the dollar amount that a physician can be reimbursed for, say, a tonsillectomy or an appendectomy, or a psychiatrist for an outpatient visit. Some means will have to be found to do something about this, or we are going to have two systems of care again. Suppose a surgeon may be reimbursed \$400 for doing a tonsillectomy under the national health insurance. Well, suppose he chooses to charge \$600. Then those patients who could afford to pay the extra \$200 would go to that surgeon, and those patients who could not pay would have to go to somebody else. Unless some means are found for dealing with this issue, national health insurance may well increase the gap between the kind of care the wealthy get and the kind of care that poor people get.

Let me close by making two comments. The first is that the health and medical care industry is an immense one. In the United States last year approximately \$115 billion were spent for medical services. Of this amount about \$14

billion went for mental health service. That is a very large amount of money and a very significant part of the national economy. One of the questions that the country faces, in the political campaigns and also in the next session of the Congress is, how committed are we to using a significant part of our total gross national product for health, medical care, and mental health services?

My final remark is that the proportion of the gross national product in the United States that goes into health and medical care is higher than that of many western European countries and than that of Australia and New Zealand, and yet we have poorer mortality and morbidity statistics than these other countries do. While we need more money in health and medical care services, we also need to find ways to spend these dollars more effectively so that they can have a greater impact on people's health and well-being.

I will close by saying that the other controversy which lurks around the corner has to do with the extent to which we should invest in clinical patient care which is dealing with the casualties of the system, people who are already ill, as contrasted with investing in preventive activity. We now know fairly clearly the health consequences of people's behavior patterns around eating, around drinking (particularly in relation to drinking and driving), around smoking, and around accidents generally. Accidents are the major cause of death up to the age of 34. Not all of these accidents are preventable, but many of them are. As people get concerned about the increasing portion of the gross national product going into health and medical care services, more support will develop for investing in preventive and educational services, and the debate will be joined.

THE FEDERAL PANEL: QUESTIONS AND ANSWERS

Question: All the speakers have referred to further information they have available. How can we obtain this further information?

Dr. Hirsh: Let me suggest that the people who organized the program here have our names and that you may feel free to get our names and write to us. But please don't write to us and say, "Gee, what information do you have?" We don't have the time — we're all overworked — or don't even want to spend the postage to send you several carloads of paper. If you have specific inquiries about specific issues, please make your inquiries as specific as possible, and then they will get attention when they are sent to us. You will not always get an answer directly from the person you write to, but that's because our job often is as a switching station, so we just send it on and we have the person who knows the most about the area respond. [Editor's Note: Names and addresses of the speakers appear in the Appendix.]

Question: Dr. Behrens and others spoke about changing trends toward decentralization of services and deinstitutionalization, and we are in the process of building State mental health programs located at State mental hospitals, and also looking to residential schools as those centers which will provide services to the emotionally disturbed deaf child. How do the others of you see the trends going and what would be your advice to those of us who are trying to build new programs?

Dr. Behrens: BEH does not have an official position on this. We refuse to have an official position because the law by itself requires that for each child there will be an individual educational plan, which outlines the least restrictive environment, and this is to be done with the parent or guardian, with due process and so on. Now, what that means is that we have got to realize that we have a lot of children today in institutions who are there more for the comfort of our society rather than for what we could do in the least restrictive environment if we would also have the resources to give these people appropriate education. I think the term "mainstreaming" is misleading, because it creates automatically a dichotomy. The Bureau's posi-

tion is that we feel that the majority of behaviors seen in a nonhandicapped child are also seen in a handicapped child. In other words, children are in many aspects much more similar than they are different, and once you approach your education from this basis you will see or realize that many children could benefit outside of an institution. On the other hand, we don't want to say there won't be any more programs in institutions. We see our responsibility as providing better educational services in the institutions if the professionals, the official representatives, and the parents agree that this is the least restrictive environment and put it into the individual prescription for that child.

Dr. Williams: As I understood this question of decentralization, it is a byproduct of the current administration. I am from previous administrations, a carryover. I don't buy decentralization in a highly specialized area like deafness. Deaf people deserve a much better break — they deserve much more, a much better share of our national effort, our State and local efforts, than is being provided. Periodically we come up with new concepts, new innovations: We're going to "mainstream" deaf people now, and that is a serious disservice to most deaf people. It can lead to incalculable problems in mental health. Deaf people need to be with peers, they need to have the contact from working and playing and associating with people who are similar to them. It is fundamental, it is basic in human development. The rare bird who is thrust into the complex challenge of the normal school — thrust, or pushed, or kicked — into the complexities of normal educational patterns when he is not equipped to absorb them or to react in accordance with his abilities, that person is, more often than not, in very serious trouble, and I'm sure that the majority of adults who have been through the mill will tell you the same thing. And that's where to find out about it — people who have been through it.

Dr. Hirsh: In answer very specifically to your question, I think one of the best recommendations is that you're going to have to function with a split brain, meaning you are going to have to continue to advocate at the Federal level, but

the probability as far as I'm concerned, over the next 10 years, no matter what administration is in power, is that we will, because of health economic reasons, move more and more toward some kind of block revenue sharing. This does not necessarily mean mainstreaming, but it does mean that it is critically important for you to develop your advocacy potential at the county and State level, the same advocacy potential that you have at the Federal level, so you don't get caught with other people making programs for you.

Dr. Kramer: As usual, you have complex questions to answer in 30 seconds. I think you are just in a real bind, and I would advise that you emphasize the attributes that you have in a given situation where you think you can produce the best result at this point, because of limited personnel and an increasing problem. If you look at some of your prevalence rates, this is one

use of data that can be made, in the age group, say 6 to 25, essentially 1 percent of the population has a significant bilateral hearing impairment. That's a large number of people. Now if you go up to the age group 65 and over, 17 percent of that population group have a significant bilateral hearing impairment. Now, one of the things that has happened as a result of deinstitutionalization is that the problem we are dealing with has not been made any simpler. You are now dealing with, say, 1,500 catchment areas throughout the United States, and all of the services in the mental health area related to that. One would, I think, have to assess the knowledge you have, where it can best be applied, and where you have the personnel needed to do it. The other important thing, I think, is to keep pressing to get the kinds of training and support that you need and to get the manpower needed to do the job.

Part IV
THE MENTAL HEALTH
NEEDS OF DEAF PEOPLE

THE MENTAL HEALTH NEEDS OF THE DEAF COMMUNITY: IMPLICATIONS FOR ADVOCACY

Steven K. Chough, M.S.W.

Mr. Chough is Coordinator of Clinical Services for the Deaf in the Minnesota Department of Public Welfare, St. Paul, Minnesota.

The number of mental health programs serving deaf children and adults expanded rapidly in the 1960's. The quantity of such services has increased, but has the quality of services improved correspondingly? Meeting the mental health needs of deaf persons is no easy matter in today's complicated society. The changing concepts of mental health services for the deaf community is a challenge. We must be constantly aware of the needs of deaf citizens and the most effective ways to serve those needs.

I use the expression "deaf community" to describe broadly the wide pattern of relationships among groups of deaf persons who share common values, fate, or function in a locality. The deaf community is, in short, a social entity of deaf persons. However, it is difficult to discuss a typical deaf community, because they are so diverse and heterogeneous. Each will vary according to its geographic location, leadership, community organizations, the kinds of problems being dealt with, and other factors. Despite this variability, a skilled mental health professional can note certain general characteristics in his deaf community and become familiar with it, so that he can work to improve its services. If the strategy he follows is concerned with preventive methods, future problems and costly therapeutic services can be lessened. He needs to have a clear conceptual grasp of the deaf community, particularly the nature of his own role in relation to the deaf community. Attempting to explain the nature of his efforts without understanding the deaf community with which he is working is like a doctor trying to prescribe a cure without referring to his patient. I would like to discuss various perspectives of the deaf community,

including deaf adults, deaf women, deaf children and their parents.

Many of us do not realize that power in the community is not as simple as classical democratic theory suggests. One sociologist in the field sees community power as a force manipulated by an identifiable elite (Hunter 1952). There is a "pyramid of power," and the small elite passes its wishes down to subordinates. The power of the elite is pervasive and one-dimensional. Other research, however, indicates that community power is somewhat pluralistic, frequently informal, often hidden and disguised, and otherwise difficult to identify (Lahl 1961, Polsby 1963). The community is polyarchical rather than hierarchical; power is diffused rather than concentrated behind the scenes.

Power in the deaf community varies from situation to situation depending upon leadership, degree of consensus, and the mechanism of deaf organizations. Deaf people do not share equal interest in their involvement in local affairs. The mental health worker needs to learn how to communicate with deaf people who are influential in the community with which he is concerned. He must also seek the support and participation of deaf individuals in order to provide mental health services effectively.

In general, deaf persons are unorganized and often unable to articulate issues or opinions in ways amenable to the formulation of strong proposals. Consequently, they are in great need of an advocate who is willing to use his skills for their benefit. When working with deaf citizens, their unique community situation should be considered.

After graduating from schools for the deaf,

many deaf adults continue their association with other deaf people through various organizations. Their tendency to seek social gratification from other deaf persons rather than from hearing people has given rise to a very tight social system. Since deaf people constitute a small group in any given community, they may know almost every other deaf individual in the area. Deaf patients are likely to feel uncomfortable in the presence of other deaf persons if they are known as recipients of mental health services.

A study showed that the rate of schizophrenia was almost the same in the general population as compared to deaf patients in New York State, but the evidence of problems of everyday life in deaf adults was much greater than among their hearing counterparts (Rainer, Altschuler, and Kallman 1963). There is, however, a possible conflict about the relationship between deafness and depression. Rainer et al. (1963) in New York observed that the rate of depression among deaf patients was not as high as anticipated. Many deaf patients in Chicago were found to have a primary diagnosis of depression, so it was concluded that frustration and isolation due to deafness combine to produce psychiatric depression in deaf adults (Grinker 1969). Many of those deaf adults who have a communication barrier with much of the world tend to have difficulties in the diverse areas of education, employment, sexual adjustment, family life, and above all feelings of isolation and loneliness. It should be kept in mind, however, that the majority of deaf adults do adapt to a severely frustrating situation very well.

When working with the deaf community, the professional needs to be aware that, like hearing people, deaf leaders or the deaf elite are more likely to think in terms of general plans, the community as a whole, and long-term benefits; whereas deaf persons at a lower level have the tendency to see such matters in terms of specific programs to meet their immediate needs and provide short-term rewards.

Women's involvement in the civil rights movement has done much to broaden their horizons. The number of working wives has risen dramatically, from 25 percent in 1950 to 44 percent in 1975. A recent Census Bureau study shows, however, that women still have a long way to go before they attain educational, economic, and occupational equality with males.

Despite many advances in women's roles in society, deaf women still lag behind hearing women in most aspects of their lives. They are more likely to be over-represented in low-paying

jobs. A New York research study indicates that the current divorce rate of deaf women is three or four times greater than that of hearing women (Rainer et al. 1963). In order for the mental health professional to help with the struggle against discrimination, he or she must see it as a mental health problem which challenges women's self-concept and which can lead to severe emotional traumas. A magazine article in *Gallaudet Today*, entitled "Women and Deafness," published in 1974, should be consulted as a significant effort to help men, both deaf and hearing, understand the woman's position and to stimulate deaf women to play a leadership role in the deaf community.

The incidence of emotional disorders among deaf children is high. Lack of communication resulting from deafness is obviously one of the greatest contributors to adjustment problems of deaf children. One study found that over 31 percent of deaf pupils in one residential school were either moderately or severely disturbed, compared with less than 10 percent of hearing children in public schools in Los Angeles (Schlesinger and Meadow 1972). In another study of 120 deaf children, 22.6 percent were found to have psychiatric disorders of moderate or severe degree (Freeman, Malkin, and Hastings 1975). The evidence is not always consistent. In a demographic study of about 44,000 deaf youngsters during the 1972-73 school year, only 8 percent were found to have significant emotional/behavioral problems (Jensema and Trybus 1975).

Efforts for primary prevention and early intervention of deaf children's problems must begin very early in life. One important step would be educating existing teachers at schools for the deaf in practical application of child development psychology and mental hygiene. Unfortunately, few schools for the deaf have effective programs to provide troubled children with mental health/counseling services. Many schools, both residential and nonresidential, are often unwilling to incorporate mental health services into the total school system; mental health "outsiders" are not really trusted by the educational personnel.

A stable, well-adjusted family is a crucial influence in the mental health of a child. A child's mental health is closely related to that of his parents. The parents, by providing their children with food, shelter, clothing, and love, foster socialization and also determine the degree and stability of their mental health.

Parents must make significant adjustments when their child is born deaf or becomes deaf in

early childhood. Most parents are not adequately prepared for coping with the unexpected burden of a deaf child. The burden experienced by such parents is beyond written description and can only be truly understood by those who have lived through it. One parent of a deaf child sharply criticized the helping professionals who advise parents to encourage the use of oral communication and to exclude manual communication. She said that such action would be like sentencing that child to a life of loneliness and maladjustment (Rhodes 1967). It is important for the mental health worker to be fully aware of the fact that the attitudes of parents toward their deaf children are the most critical influences upon the mental health development of those children.

One of the factors related to the effectiveness of a mental health program is the public awareness of the program and willingness to accept mental health counseling services. A questionnaire, "Opinions about Counseling Services," was distributed to 139 deaf members during one formal session held at the convention of the State organization for the deaf in Minnesota last year. We found that one out of four respondents did not seek help because of the feelings of shame; more than 30 percent of these respondents pointed out that they would not go to a professional counselor because of public stigma, that is, what other people thought about their seeking help. Finally, one out of four did not want to seek counseling because they felt that the counselor would not be helpful at all.

Hollingshead and Redlich (1958), conducting a famed study of the relationship between mental illness and social class, found that upper-class members have more favorable attitudes toward mental health professionals and are more willing to accept mental health services than those in the lower classes. While lower-class neurotics are more likely to express their problems in somatic terms, higher-status neurotics are more likely to express them psychologically. The mental health worker with the deaf community finds it useful to keep in mind Hollingshead and Redlich's conclusions that mental disorders cannot be understood independent of socioeconomic conditions, which influence the decision to seek help.

While seeking to intervene in mental health problems, the professional must keep in mind the dynamic interrelationship between illness and environment. Effective intervention rests on the assumption that the causes of social prob-

lems lie not only in individual dysfunction but also in social or system dysfunction. For instance, it makes no sense to help a deaf patient get food stamps while ignoring the system that makes the gaining of food stamps difficult for him. Or he may have more than individual problems when he comes into a mental health clinic, such as not enough money, troubles with the family, lack of a decent job, or no proper housing. We must work to achieve changes in human relationships and social institutions in order that counseling can be useful outside of the office in the client's day-to-day life.

No simple solution will make a mental health program more effective. Many different strategies and tactics are utilized to provide efficient mental health services. One of these methods is *advocacy*. The role of advocate in consumer interests has recently received a great deal of attention in the social/mental health literature of deafness and is rapidly growing in importance. The concept of advocacy is, however, difficult to define because it has various meanings—depending upon the professional's background and the needs of the group he is serving. We have no empirically proven guidelines to follow in an advocacy program, for actual experience in advocacy has been relatively limited.

The role of advocate can perhaps be better understood by first looking at other professionals who work in community oriented roles. The first is the *enabler* (Ross 1955). This mental health professional works to encourage the expression of views from all groups in the community and to achieve effective interaction among them by directing them toward agreement on the common problems. Cooperative relationships, compromise, and adjustment among groups are important objectives. The enabler, in short, strengthens community participation and integration by developing more constructive relationships among the community people.

The second professional who affects growth in the community is called the *change agent* (Lippitt 1958). This person is similar in many respects to the enabler. The change agent focuses on improving communication and integration in order to build up the community's capacity to accept changes in the future. He provides information, brings the client's perceptions into realistic terms, and works to change attitudes and values. In other words, he attempts to enhance the coping capacities of the community members.

A third professional, the *planner* (Morris and

Binstock 1966, Kahn 1969) attempts to identify both the needs and the deficiencies which operate in the community and then develop means for solving or preventing social problems. Planning without adequate investigation of relevant social facts is utopian thinking or traveling blind. The planner therefore engages in careful research, evaluates the pros and cons of alternatives, and then recommends a course of action to those who make the decisions in order to improve social conditions or services.

Finally, the *advocate* (Grosser 1973) acts in much the same way as the three previous professionals. He works to the interests of disadvantaged groups by increasing their power, their participation in decisionmaking, and their status. He negotiates on behalf of his client, in situations where they are not skilled or not powerful enough to negotiate for themselves. The advocate utilizes two major strategies: first, he strives to obtain a greater and more appropriate share of the goods and services for his particular group. In gaining these goods and services he works toward the elimination of social injustice and the promotion of human rights. Secondly, he arouses and organizes disadvantaged citizens and teaches them what the appropriate targets and tactics are for their collective actions.

The role of advocate is derived from the field of law. He must always keep in mind the needs and welfare of his client groups and not his own. He must keep in mind the question, "Who gets what, when, where, why, and how?" Among his responsibilities are the provision of leadership

and resources of challenge the organization's position, making them more faithful to their legal, human, and social obligations. He needs to be able to engage in the political process as a "social partisan" for the interests of his constituents. Better human and humane services are his sole goals.

The advocate's major strategy involves stimulating the disadvantaged groups toward organizing themselves into a cohesive body. He then acts as their spokesman. Many mental health workers, however, often shun the advocate role because they view themselves solely as therapists. We have a responsibility to the total person, to total human services, and not just to specialized areas of intervention. In many cases, unsatisfactory mental health services are a result of both inadequate commitment and lack of understanding on the part of the advocate. The advocate, in other words, will determine to a great degree the success or failure of mental health programs serving the deaf community.

Advocacy began to establish itself firmly into the human services system during the mid-1970's. It is an effective method developing out of a number of constructive opinions, proposals, ideologies, strategies, and hopes. If its importance and usefulness as an efficient method of mental health services can be realized, deaf persons will be rewarded with the reality and gratification of receiving satisfying services. Accompanying this, there must naturally follow a wealth of other good things: self-confidence, pride, and the respected citizenship which we, deaf and hearing alike, all seek.

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MENTAL HEALTH NEEDS OF DEAF ADULTS

Frederick Schreiber

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When I heard I was to speak before Ms. Locke, I knew it wouldn't be easy. I knew Ms. Locke and Dr. Vernon would be on this panel and I thought she would be first this morning to talk about the mental health needs of parents and children. Then Dr. Vernon would talk about the mental health needs of adolescents. Then we would come to the mental health needs of adults, and all I would have to say would be, "Me, too!" because the mental health needs of deaf adults are extensions of those of children and adolescents.

But even though the order of presentations on this panel is not as logical as this deaf adult thinks it should be, I still can say, "Me too!" Throughout Ms. Rosen's speech this morning was a very pervasive theme which influences all our needs, the needs of deaf people, and that was a poor self-image. Basic to the problems we have in the area of mental health is the influence of education which gives us the picture that deafness is a negative thing. Throughout our school life we are taught that speech is beautiful, that speech is good; if you can't speak well, you are inferior to other people. Schools refuse to use other approaches, or sign language, at which the deaf child can excel. That continues to this day in deaf education. As a result, the deaf person grows up with the feeling that he is inferior. I suppose that in many instances this feeling is true for all handicapped people. Obviously, a person who is less than whole is less than perfect, and therefore all handicapped people have some feeling of inferiority to that extent. But deafness intensifies this greatly.

Recently I met with a group of people who call themselves The American Coalition of Citizens With Disabilities, which is an umbrella organization of all handicapped people. At the original meeting of the group we were discussing organization. Handicapped people were talking

about who could be regular members of the organization, which would be organizations of handicapped people. Then someone proposed associate members, which would be organizations interested in helping handicapped people. And the disabled said no, they didn't want any "able-bodied" people in their organization, because able-bodied people tend to dominate handicapped people. Able-bodied people tend to place their views over those of handicapped people. I think this attitude specifically relates to deafness. I tried to point out then that all people who can hear are considered able-bodied by deaf people.

It is perhaps a very sad documentary, but it is true. All people who can hear are able-bodied as far as the deaf individual is concerned. For many years we assumed that many, if not all, of our problems stemmed from this particular basis. We assumed that the ability to hear had some magic significance which gave more credence to the views and opinions of those who hear over the views of those who do not. We are depressed. We associate, as Steve Chough said, with each other, because that is the only place where we are equal. By associating with hearing people we feel inferior. As with other minority groups, the only place we can feel comfortable is with other people who are equally inferior. Therefore, we need to raise our aspirations and goals.

A short time ago the National Association of the Deaf established a legal precedent to fight for the equal rights of deaf individuals in the State of Minnesota. But many of our leaders said, "No, don't do that. You will make the establishment close ranks against you. You will make people fight you if you resent the kind of treatment that you are getting." There are many among us, again as Steve said, especially among the "successful" people, who don't

worry too much about closed ranks or the attitudes of people, who have been trained not to rock boats and are not willing to fight the establishment.

This reminds me of a story about a deaf couple who moved into a very exclusive community. One morning their little boy was playing outside, when the neighbor came out and said, "Good morning." The little boy said, "My father says we are just as good as you are!" The man was puzzled and said, "Why?" The boy answered, "Well, our house is just as good as your house." So the man looked at the deaf man's house, and sure enough, it was the same kind of house. So he said to the boy, "You're right," and he left. About 2 weeks later the same thing happened again, and this time the boy said, "My father says we are just as good as you are!" So the man said, "What brought that on?" And the boy said, "Our car is just as good as your car." The man looked and said, "True enough, it is." But the third time it happened, the little boy said "My dad says we're better than you are!" And the man said, "Well, now what?" And the boy said, "Well, we ain't living next door to no damn dummies!" There is a perfect example of the deaf self-image.

In the process of working on this many years ago, one of the things which really stuck in my memory was an article that appeared in, I think it was *The Western Pennsylvania School for the Deaf Magazine*, in which a student was writing and recounting his experiences at college. At this particular time the boy was a student at Bethany College. He had previously gone to Bucknell University, but he found Bucknell too large, too impersonal, and therefore he had transferred to Bethany, where he was doing very well. In his article he said — and this has stuck in my memory all these years — "Of course, I have to copy notes in class to keep from falling asleep during lectures, but I am doing very well." What on earth made him think he was doing well in a college where he was obviously bored to tears?

What is so wonderful about hearing people anyway, that deaf people should get the impression that they should look up to *all* hearing people, regardless of their individual worth? But this is what's happening to most of us, even to deaf adults and to the people who practice advocacy. We still have these kinds of feelings. We feel guilty if we disagree with our mentors. We feel that by going our own way we are flying in the face of providence. We are flirting with calamity. Our objectives, our aspirations are

geared to that particular position, that we are inferior.

We have just heard in the presentation on the deaf woman — the deaf woman, incidentally, is an adult; that may not often be admitted, but it is true — an evaluation of the career roles of deaf people. That evaluation is true and is not limited just to deaf women, but applies to men also for the same basic reason. We are taught not to try. We are taught that trying too hard is to be a failure. Our parents were taught that way. Our parents were taught to over-protect us as children, or to have very low expectations of what our abilities and our accomplishments could be. To this extent, it happens to us because we are deaf.

I worked for almost 20 years before I became a professional haranguer, and during that time, as I worked with my coworkers, I learned that whatever happens to a deaf individual happens to him *because* he is deaf. I just recently spoke to an individual here in the Washington community who was having problems at Gallaudet College. I said, "Well, I really can't help you — or some such thing as that — because Gallaudet's purpose is to work in the field of deafness, and so if you are having problems there it is obviously not because you are deaf, but because you are you." He said, "no," I was wrong. What was happening to him was happening because of discrimination against him because he was deaf. Everybody else who is deaf there was doing O.K., but because this one person was having problems, it was because he was deaf. Talking with deaf people who work in the Government here, I hear the same thing. "My boss bawled me out because I am deaf." "Well, did you make some mistake?" "It doesn't make any difference if I made a mistake or not; he bawled me out because I am deaf." It doesn't occur to them that maybe they were wrong and made the mistake in the first place or that getting chewed out for making a mistake happens to everyone. This kind of situation is not uncommon.

When we are talking about the mental health needs of deaf people I do not think I should discuss, "How many counselors do you need? How many facilities for mental health services do you need?" I think you know that better than I do. But I think also that until we attack the fundamental needs of the deaf person, that is, his self-image, his self-disdain, and the attitudes that cause deaf people to have this poor self-image, we will continue to have mental health problems. We will continue to have a need for the development of mental health

programs of great scope. As far as the figures from New York and Pennsylvania go, showing that the deaf people have about the same amount of mental health problems as other people — I'm not a researcher, but I can't agree. I think deaf people are better actors than most people realize. We, as deaf people, are taught to say what we think you want to hear. We seem to know instinctively what is the right thing to say depending on whom we are talking to. It happens time and time again, even with children — even children know what they are supposed to say and they say it. We are very, very receptive to suggestions. That is part of what is involved in the mental health problems at all generations, from the infants all the way up to adulthood and the aged.

We need to get into this area. We need, first of all, to educate the educators about the mental

health needs and the importance of the self-image of the deaf children, about the kinds of things they say to the mother, that the mother latches onto. We need to demonstrate clearly to everyone that ears are cheap — I use that phrase often. We need to remind people that it is what is between the ears that is the most important part of the human body. We have many examples to prove that is true. I know the director of a State department of rehabilitation who has a respiratory disease. He spends more than half his day in an iron lung. The director of that department is a good example to prove that if you use your mind, if you have one and if you are allowed to, you can overcome all your disabilities. These are some of the things we need to do to promote the mental health of deaf adults.

MENTAL HEALTH NEEDS OF THE DEAF WOMAN

Roslyn Rosen

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In talking about the needs of the deaf woman, it seems difficult to separate the problems experienced by deaf women as opposed to hearing women, and by deaf women as opposed to deaf men, since femaleness is the common denominator in the first category and deafness in the second. There you have it, the deaf female has been handed a double-whammy, and if she is also black, that makes it a triple-whammy! However, there are several unique needs that I'd like to touch upon in talking about the deaf woman.

In a workshop focusing on the psychology of deafness (headed by Dr. Allen Sussman) not too long ago, the panelists, who were Gallaudet College students, stated that the greatest handicap of deafness was the attitude of hearing people toward the deaf. In treating the topic of needs of the deaf woman, I'd like to expand the affective domain to include the attitude toward self, or self-perception. While it is true that self-attitude is a result of environmental circumstances and conditioning from the cradle onward, let us deal with the "after-the-fact" situation, namely the adult, and look at the problems and needs of the deaf woman.

To begin with, deaf women have long been exposed to and expected to fit old stereotypes of the female whose role includes submissiveness, domesticity, inferiority, acknowledgment of male superiority, and the expectation to be protected and cared for by males.

First of all, deaf girls need to realize their self-worth and to respect themselves as capable and valuable human beings with brains and emotions of their own. They must learn to stand up and speak up for their beliefs and rights. They need to be more assertive and to have confidence in themselves and their ability to deal with other people in an open, honest, and nonthreatening manner. They must also learn to expect the

same straightforward behavior from other people and to cope with situations independently. Some symptoms of assertion-avoidance behavior are lashing out, procrastinating, repressing feelings, feeling "low", self-pity, and giving in to please others. Assertive training should be offered to deaf school girls as a regular part of the school curriculum.

Another training need is evident in the area of sex: sex education, roles, and expectations. Often when a young girl discovers that a boy likes her, she will feel flattered and maybe even become attracted to him. Not always does she stop and think, "Hey, do I like him, too?" She must also be able to deal with her own sexuality and be able to handle male advances. Whether she should or shouldn't is a moot question in this day and age, but she should be fully aware of herself as a person, her role, her self-respect, and use these criteria in her relationships, and of her right to refuse if she so chooses. And then there are the issues of birth control, abortion, and rape, which are practically foreign topics to young deaf girls. Some think that birth control means only the pill, and some even ask if they should take the pill the night before or after. It is inconceivable that they are given birth control measures without full information on purposes, alternatives, and usage instructions.

Deaf women may be conditioned to male doctors — being cared for, examined, and even operated on by them — but how many actually *talk* with their doctors? Generally speaking, they may not fully understand what is happening or they may not have full information about their bodies, health, and needs. They need to know what kinds of questions to ask, how to get and use the information, and to expect such without being afraid of wasting the doctor's time and consequently of courting his irritation with

time-consuming questions and communication techniques. Some doctors insist on having interpreters on hand in order to facilitate communication; this may cause the patient to feel a loss of dignity and privacy, especially if she does not yet know or trust the interpreter. In addition, how many deaf women talk to their doctors about sexual or marriage problems the way hearing patients do? Given that the general doctor may not be the best person to handle questions like this anyway, what other resources does the deaf woman have? How many professionals are there in the field who know and understand the deaf? How many deaf counselors and psychologists are there? Can you come up with more than two names of deaf women professionals in the field in the entire United States? Would it be better for the deaf woman to confide in a deaf female friend instead? Besides the empathy and morale boost, communication can happen in native Signs, which is more comfortable in stressful situations, anyway. Obviously there is a need for more trained professionals in the field who are aware and sensitive about deafness, knowledgeable in manual communication. But when we get down to the nitty gritty — areas that are sensitive, with patients who are low verbal or very disturbed — there is a definite need for deaf professionals and especially deaf female professionals in the field.

Let's take a look at the needs of the deaf homemaker. Her husband is out and at it all day on the job, but she stays at home and her horizons narrow tremendously. Dealing with the public is very difficult. Relationships with the neighbors and participation in the community may happen only on a superficial level. (Yes, it's a beautiful day. Oh, your kid's tooth fell out.) Her children go to school, but does she join the PTA? Forget it. Why go and just sit there like a bump on a log, seeing the hustle and bustle but missing out on the meaning? Yes, she'd be glad to bake a cake for the PTA sale, but one or two such public meeting experiences may be enough to turn one off. Yet, it is her right as a citizen of the community and this Nation to expect full accessibility in terms of elimination of communication barriers at public school meetings and board meetings, government-funded programs and service agencies, and to expect availability of programs on an equal basis and availability of qualified interpreters. Awareness of these rights is coming but at an incredibly slow pace. The deaf woman may become increasingly dependent on her children to satisfy her communication needs, to interpret for her in

many situations including those that may be stressful for the youngsters such as in doctors' offices or lawyers' offices, and sometimes to help make decisions for her and to be her link with the community. This can lead to confused roles and increased conflicts within the family. Counseling in value clarification, role expectations, and family life can be helpful. Continuing education, understanding of how to use interpreters, knowing what services are available and how to get them, increased program outreach efforts, and communication are some evident needs.

A recent research study by one of the graduate students at Gallaudet College showed deaf females to have low self-perceptions of themselves as persons and to have low career aspirations. One reason for this is the stark lack of female models with whom they can identify, upon whom they can hitch their future career dreams. Deaf girls in schools may be exposed to deaf women only in the roles of teacher, dormitory counselors, homemakers, office clerks, factory assembler, and food service helper. How many schools have deaf female administrators? How many agencies and companies hire deaf female professionals? How many schools bring in deaf women to talk about other kinds of careers available? The vocational education programs may further reinforce this separation by training the girls in typically feminine occupations and the boys in the more traditionally masculine occupations which, incidentally are better paying. With Title IX, this discrimination is ending; however, it cannot erase the scars left in our deaf female adults. Rehabilitation workers with the deaf can play a vital role by exposing them to various career possibilities, encouraging them to aim higher, and counseling them to go for that extra training that ultimately will enhance employability and upward mobility possibilities. In addition, deaf persons should know about EEO and AAP regulations and also that hearing people do change jobs because of the difficulty of finding jobs and of adjusting to new situations. Furthermore, deaf women may avoid aspiring for better jobs and better pay, increased training, or advanced degrees, if they view such as being threatening or unacceptable to deaf males. If they view their relationships as a closed model, the women cannot hope to advance or change roles without upsetting the balance or role expectations. Consequently, in order for change to occur, not only should the woman get training, but so should the man. You know, Women's Lib means Men's Lib, too. Training can

occur as a part of a continuing education program, a workshop in a deaf club, or with a small group in a home or community center.

In summary, the training needs of deaf women include:

- (1) assertiveness, human relations, or effectiveness training;
- (2) awareness of rights:
 - (a) laws prohibiting discrimination (EEO, AAP);
 - (b) availability of interpreters and services;
 - (c) accessibility rights;
- (3) sex education, marriage, child care;

- (4) career exploration and training opportunities;
- (5) awareness of what services are available, where, and how to get them;
- (6) dealing with hearing people, professional people who don't know beans about deafness, and agencies in securing full services and full rights as citizens.

Other needs in the field are:

- (1) increased public awareness of deafness and willingness to deal with deaf people as persons;
- (2) more trained professionals fluent in signs;
- (3) more deaf male and lots more deaf female professionals in the field.

MENTAL HEALTH NEEDS OF DEAF CHILDREN AND THEIR PARENTS

McCay Vernon, Ph.D.

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Mental health services for children in general are grossly inadequate to the point of being a national disgrace. Of these mentally ill children in need of help, no single group is more destitute of services than emotionally disturbed children who are deaf.

In looking at the mental health needs of deaf children, two perspectives can be taken. One involves an analysis of the psychopathology that exists in deaf children and describing the treatment needs of the children with these problems. The other is to examine the gaps in available mental health services which presently exist. What follows will be an effort to combine the two approaches.

Parental Needs of Deaf Children

The major source of preventive mental health for the deaf child, even more than for the hearing child, is parental. The issue is what psychological needs the deaf child has of his parents, which are over and above those needed in a parent by a hearing child. There are four.

Feelings About Deafness

Having a deaf child is traumatic to a family. It arouses responses such as grief, denial, guilt, anger, and frustration which are of an intense and deep nature. Unless these feelings are worked through in what is called a mourning or grief process, they are tremendously destructive to the entire family constellation in general and to the mental health of the deaf child in particular.

Parents are most ready to resolve these feelings around the time the diagnosis of deafness is made. A failure to work through the grief fully at this time leads to the fixation of unhealthy coping mechanisms such as denial, guilt, or

reaction formation. These pathological defenses then become chronic. Thus, the deaf child faces unrealistic expectations, rejection, overprotection, and other pathological parenting behaviors which doom him to emotional disturbance, unhappiness, and a crushing of his potential for life.

Information

Along with needing parents with healthy feelings toward him, the mental health of a deaf child depends upon his parents having some very specific factual kinds of information. For example, parents must know intimately the educational options open to their child. This includes options of educational method, of school system, and of programs within a system. Errors of judgment in these key areas can do irrevocable damage to a deaf child's hope to develop communication with other human beings or can leave him functionally illiterate for life. When this happens to a deaf child he frequently becomes mentally ill. If not psychotic, he at least becomes so deprived as to be what psychiatrists have called "surdephrenic" or of "primitive personality."

The young deaf child is powerless to make the educational, linguistic, and prosthetic decisions that can contribute to his mental health or mental illness. Professionals are in such intense conflict over many of these issues that they do not always offer basically consistent advice and information. Consequently the parents are left to make crucial life-determining educational, linguistic, and prosthetic decisions for their deaf child. For these decisions to be such that mental illness is avoided and potential realized, the deaf child needs an exceptionally well-informed parent.

Communication

Parent-child communication, child-sibling, and child-peer communication are absolute minimum requirements for full psychological development in a deaf child. For these to occur it is necessary that some form of manual communication be used along with oral communication.

Despite the vehement feelings and irrationality which pervade the area of communication, the evidence is clear. The combined use of oral and manual systems (total communication) by parents and other family members is a must if the deaf child is to get the most possible help from his parents and if his probability of mental health and of achievement is to be maximized.

Activist Parents

I have had the fascinating experience of being with Dr. Hilde Schlesinger, famed child psychiatrist in deafness, several times when parents who have done everything right have come to her with 6-year-old deaf children. To clarify, these are parents who have worked through their feelings about deafness; they have become thoroughly familiar with educational, linguistic, and prosthetic options open to them; and they have mastered total communication. Thus, their 6-year-old child has the basic language and communication skills needed for beginning regular first-grade work, and they are looking for a program. The irony this creates is that there is often no school that is prepared to educate such an unusual deaf child. Instead, the schools tend to be prepared for the other 99 percent of deaf children who come to school with very meager or totally deficient language.

I have heard parents say to Dr. Schlesinger in almost macabre jest, "What are we going to do with this monster we have created?"

This brings up the fourth mental health need of a deaf child from his parents. The parents must be able to exert the pressure needed on our political-economic system that is required to change it drastically. This means to change the educational system so that it serves the deaf child instead of destroying him.

For an example of a destructive system take the one in Baltimore City. There are deaf children who are at best at a third- or fourth-grade academic level, who sit every day in high school classes of 30 or 40 hearing children. They cannot lipread lectures, yet they get no interpreters or even note-takers. Because of their low aca-

demic levels they are unable to read their textbooks. These conditions are present all over the United States in thousands of classes involving deaf children every day. It would be hard to deliberately design an educational program more certain to destroy a child's potential for education, self-respect, and mental health.

Thus, the mental health needs of a deaf child from his parents often means parents who either have the capacity to change the local educational system or to relocate to an area where the system is adequate. For many parents this is an awesome responsibility which they are unable to meet.

Mental Health Services Needed

In sum the major mental health need of a deaf child is parents who:

- (1) worked through their feelings about having a child who is deaf;
- (2) are knowledgeable about available opportunities, educational issues, hearing aids, and language development;
- (3) can and do communicate with their deaf child; and
- (4) who can use the social system to their child's advantage.

To provide a deaf child a parent with these qualities requires the delivery of counseling services almost immediately upon the diagnosis of the child's deafness. These services should consist of three major factors. First, an opportunity to talk and work through the feelings the parent has about having a deaf child. Second, the provision of constructive ways to cope with deafness. This includes sign language instruction, information on language development, data about educational methodology, data about the location of schools, and information on the existence of organizations such as the International Association of Parents of the Deaf.

Such counseling service can and should be provided for urban parents in a speech and hearing center or a preschool where the deaf child is served. For rural or small town parents the service may have to be provided at residential parent institutes held on a regional or statewide basis in a State school for the deaf. Such institutes need to be followed up with some sort of local service or itinerant program.

The key to the effectiveness of this counseling service is the nature of the groups in which the counseling occurs. Historically parent counseling groups have consisted of parents of young deaf children and a therapist. This model

is inappropriate and, as has been demonstrated at the Tracy Clinic and elsewhere, fails to do the job adequately.

The model for parent counseling has to be a self-help model patterned after Alcoholics Anonymous or Synanon. In this model deaf adults and parents who have successfully raised deaf children participate along with parents who have just learned that their child is deaf. This model has been demonstrated to be of great value. Its tremendous advantage over the "Tracy Clinic" model is that it involves parents who have already successfully coped with raising a deaf child as well as deaf adults who have coped with deafness.

By contrast, the Tracy Clinic model puts a lot of parents of newly diagnosed deaf children in together with a therapist who is skilled as a

psychologist, but who has little or no experience with deaf adults or with what coping techniques work for deaf adults or even adolescents. It is a sort of a "blind leading the blind" model. It is analogous to Alcoholics Anonymous trying to function exclusively with practicing alcoholics instead of with a mixture of these with those who have successfully coped with alcohol. If parents were provided this early comprehensive counseling-education service, the number one mental health need of deaf children would have been met. The number of psychotic deaf children would be drastically cut. Even more importantly, the huge percent of deaf adults and children who are under-educated, under-employed, and frustrated would be reduced tenfold.

MENTAL HEALTH NEEDS OF PARENTS OF DEAF CHILDREN

Mary Ann Locke

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Identifying the mental health needs of parents of deaf individuals is not a simple matter of just listing them one, two, three. Because of the complexities of deafness, parents usually experience a wide range of emotional feelings, of guilt, anxiety, despair, and general helplessness. In addition, they feel all alone with the problems of their child, from the initial diagnosis until the child reaches adulthood.

The single most traumatic experience for parents is the actual diagnostic stage. Their frustrations are compounded because the "expert" they see is not usually trained or prepared in the field of mental health, and thus these experts are not aware of the parental anxieties. Parents often feel that their questions and concerns are too insignificant to relate to the expert, because they are wasting the expert's time. At this critical diagnostic stage, this aloneness stage, parents also need the assistance of other parents on the personal level and also at the parent group involvement level. The techniques of self-help, similar to those used by Alcoholics Anonymous, need to be employed. Parents' concern with regard to their child covers all the areas of deafness, in addition to the normal problems of child-rearing, the complexities of adolescence, the total needs of the family, the parents' individualities, their careers, their marriages, as well as their own leisure time activities. Being a parent isn't easy, but when you add deafness, the frustrations are compounded.

The communication stage or the educational stage is another level of frustration for the parents. Here the parents face the age-old battle of the professionals, or maybe better stated, the professional controversy of oral versus total communication. This educational decision is the right and the responsibility of the parents to make. It's not an easy decision, it's not an

unemotional decision to make. This decision affects the welfare and the well-being of the deaf child as well as his family. Communication is vital: but how? When? And whom do the parents believe? Which choice does the parent make? Will it really be best for the child? The unexpressed tensions continue to build and the parents continue to flounder. Each professional presents his own views, his own research and documentation to support a particular method. Methods become the issue, not the welfare of the deaf child or of his family. Parents only see one side of the issue sometimes, because of the uncooperative nature of the professionals involved. Many parents have no communication in the home with their own child. They pay for expert advice, only to discover later that they have been living with a little stranger. They don't understand the child, nor does he understand anything that's happening within the family. Parents continue to feel all alone in this constant struggle.

Let's assume the parents have seen both sides of the issues, and they accept the philosophy of total communication. This decision was not made without a great deal of inner conflict. Now the parents must learn to sign and fingerspell. Many parents who enter a beginning sign class for the first time are very tense people. The rest of the class is having a good time and think signs are fun, but not so for the parents. It's vital that they learn in order to communicate with the child. It's not a game to them; it's a deep desire to achieve. It's imperative to learn. They can't afford to flunk out. Their child's future is at stake. This imposes additional stress. When the parents sometimes find out that they don't have the ability to sign fluently or gracefully, that they often are the worst ones in the class, that they are the slowest at retaining signs, that they

can't make every class because of work schedules, babysitting problems, or sick children, they fall behind. They experience a tenseness and an urgency which leads to depression.

Parents need to be reassured that communication is vital. They do not need to become skilled interpreters for the deaf, but they do need to begin to communicate with their child on whatever level that child is on. Once they master a few signs, they're eager to talk with their child, but the child doesn't understand. The parent wants to make up for all those years of lost time, but perhaps the child is only learning to sign, or even worse, their child has become so skilled at sign, that he is often impatient, or he simply does not understand the new signs his parents learned in class. Again the tensions mount. Why can't the parents get their act together? They've tried everything; sign language is the last resort, or so said their past experience and their brainwashing. They now question their decision and they continue to flounder.

Educating the preschool deaf child forces the parent to become the child's teacher. Each daily situation becomes a teaching and learning experience for the child as well as the parent. They lose their identity as father and mother, and the new role of teacher creates additional stresses and tensions within the family unit.

Through a series of trials and errors, the parents begin to latch onto anyone who seems to know a little bit more about deafness than they do. Many parents are willing to share their experiences with other parents. Many parents will tell other parents many things they would not be willing to discuss with the experts. But still, these people are not trained counselors. When parents are encouraged to mingle and to share with deaf adults, sometimes they have a tendency to go overboard in their relationships. By this I mean that they actually believe everything exactly as the deaf adult says it and do what the deaf adult tells them to do with their child. The deaf people they meet are not counselors. They have no training in mental health procedures. The parent can discuss with deaf people about what it's like to be deaf, but the deaf adult does not meet the mental health needs of the parent.

Oftentimes parents become so involved in searching for services, learning about educational trends, parent groups, and adult deaf people, that they ignore their other hearing children. One can know parents for several years without ever knowing that they have other children in their family. One naturally assumes

that the family has only one child and that that child is deaf. Many times parents concentrate on the deafness to the extent that they lose their own identity and can relate to things only in connection with deafness. They often lose their places in the community and only have friends who have other deaf children or friends who work in the field of deafness. Their main topic of conversation is deafness, regardless of where they are or with whom they are speaking. Some parents actually exploit their deaf children without ever meaning to do so, solely in the name of helping, to the point where the deaf child experiences humiliation and the loss of respect for his parents.

Many people feel there is an unusually high rate of divorce among parents of deaf children. A recent study in Connecticut indicated that 35 percent of parents with deaf children are either separated or divorced. Divorce is the new American lifestyle; but does deafness impose additional stress on the marriage? More research needs to be done on this topic before any more final statements can be made with regard to this. However, we do need to recognize that marriage counseling centers are not adequately prepared to handle the problems when deafness is mentioned. So where do the parents of a deaf child, with marital problems, go for these services?

Parents were not, and still are not, considered an integral part of the educational, psychological, vocational, or social life processes of their child by educators, audiologists, doctors, or even school officials. They are viewed by many professionals as trouble-makers, militants, and by some of the deaf people themselves as dogooders who really don't know what it's like to be deaf. Parents are relegated to the role of observers rather than participants in the total life process of their own deaf child. They try, but it never seems to be enough.

In addition, parents are continually experiencing a series of frustrations with neighbors, relatives, their child's playmates, school officials, as well as the average man in the street who knows even less about deafness than the parent does. Parents continue to ask: when does it end? Does it get any better? It seems we just get over one crisis, only to be thrown into another. But whom do they ask? Where do they go? They continue to flounder, and the unexpressed tensions grow.

With the birth of the International Association of Parents of the Deaf, parents for the first time in history have a home base through which they can be assured of realistic and free-flowing

information. They have one central location where their voice can be heard. They finally have an organization which serves on the national and international level as a catalyst in the delivery of services to them for their children, an organization providing an understandable explanation of deafness on all levels. But the IAPD does not, and cannot, provide the expertise, nor does it have the capabilities to actually provide individual counseling services. The IAPD can only reassure parents that they are not alone and refer them to other groups and other agencies. However, the IAPD is here today in

order to once more voice our needs and our concerns and speak on behalf of the other parents, in order to make you aware of our problems and concerns.

We need your help. We need counseling programs at all the stages of crisis, and we don't want to have to go it alone. But most importantly, we do want to help our children. I hope that you will include in your development of programs the various needs of parents and try to meet the needs of parents in your various counseling programs and also in the training procedures for mental health workers.

Part V
ASSESSMENT, TREATMENT,
AND RESEARCH, WITH A
VIEW TO THE FUTURE

PSYCHOLOGICAL ASSESSMENT OF THE DEAF PERSON

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Since I have only half an hour to discuss the salient and necessary aspects of psychological testing with deaf people, I'll do my best within this impossible time by beginning with a brief historical sketch. Following this will be a discussion of current developments in this area, then a conclusion with my thoughts of what might constitute appropriate testing with deaf people.

Six years ago the American Psychological Association mandated the imperative to protect the right of each individual to be soundly evaluated and responsibly served. With a population of deaf Americans constituting for the most part a manually oriented clientele, has service psychology complied with this imperative? What answers to this question do history and current developments give us? Depending on one's view, either the answer is a resounding "No!" or we satisfy ourselves for the moment that there are more questions than answers.

In the report of the Spartanburg Conference on the functions, competencies and training of psychological service providers to the deaf, now in press, Edna Levine presents an excellent commentary and description of the history and current state of the art. In brief, psychological testing with the deaf began in the late 19th century at a time when there was concern about the mental classification of atypical school children. This concern had generated the construction of the Binet-Simon Intelligence Test and foreshadowed the psychological testing movement as it is known today. Beginning activity in this area with the deaf was spurred and maintained by educators of the deaf until the advent of Rudolf Pintner who, from 1915 to 1942, was chiefly responsible for most of the psychological work and research.

One important outcome of this early activity demonstrated the practicality and potentiality

of the objective psychological examination. However, the first translation of the Binet-Simon Intelligence Test into English in 1910 was also significant in that it presaged in large part the present-day indecision regarding research results. More will be said about this shortly. Current conclusions from research run the gamut from stating that deaf people are mentally deficient to claiming that they are not; from stating that deaf people have more personality problem tendencies and present more maladjustment than hearing people to claiming that they are no different from the general population of non-deaf people; and from stating that the tests themselves, standardized on the hearing in the first place, are responsible for the conflict in the findings to claiming that the condition of deafness itself is the problem.

Current criticism of psychology in the field of deafness is directed at all three components of the testing situation: the deaf subject, the test, and the psychologist. The deaf subject being tested is questioned for his actual understanding of the language and concepts used in many psychological tests. Questions are raised about the use with the deaf of tests standardized on the hearing. And psychologists are criticized for their lack of familiarity with the deaf subject of their examination. These criticisms encourage the asking of questions in the right direction. The rest of this presentation will focus on the "psychologist" component of the testing situation and attempt suggestions that may lead us further in the right direction.

Until the 1950's, no psychologist to my knowledge had studied the sign language of the deaf. Pintner himself foresaw that research in the language of signs of the deaf would lead to the wide field of the significance of facial expression and gesture in communication between

men. Dissenting views to Pintner's, however, were the rule rather than the exception. Zeckel, for one, despaired of learning more about deaf individuals via the language signs and declared that the lack of hearing and speech impedes the development of the psychic intellectual life of the deaf person or retards it in comparison with other people. It comes as no surprise then that, in Levine's 1974 survey of psychologists serving the deaf in the United States, about 90 percent of the respondents (N=174) reported themselves unable to communicate effectively, if at all, in sign language with their deaf clientele. Although only 37 percent of the respondents (N=156) reported communication as a major difficulty in testing, this is attributed to the fact that many psychologists use tests that require no language for administration or response and, therefore, present no apparent problem in communication. Even so, this denial of communication as a major difficulty in testing may also be attributed to the fact that the obvious failure to master sign language makes for frustration, thereby for putting emphasis on the primacy of spoken language and blame for difficulties in testing on other sources.

Why this emphasis on the importance of American Sign Language usage by psychologists in the psychological testing of deaf people? What would be missing from psychological testing data if American Sign Language is not used? It has been my observation time and again that most deaf persons seem more comfortable when using this language (Ameslan) in responding to psychological tests. Another observation is that Ameslan seems to enable the deaf subject to give responses that contain a more qualitative flavor, particularly to personality techniques such as the Rorschach, and this in turn gives a fuller and more informative description of personality. Many deaf individuals who can and do use spoken or written English are often concerned that the intelligibility of their speech may leave much to be desired and/or that their English may be "bad English." Consequently, the resultant inhibition in their verbal responding leads to the likelihood that a deaf subject will respond to an inkblot with just one word, say, "butterfly." By contrast, when using Ameslan, he is much more likely to respond to the same inkblot with something like "a bright yellow butterfly flitting from flower to flower." This latter response has the kind of information in it that is more revealing of the personality and further contains response elements that are among the most important in Rorschach psycho-

diagnosis, namely movement and color. Movement responses, for example, are interpreted as representing such personality-related attributes as inner vitality, pattern of intellectual operations, index of creativity, and manifestations of fantasies related to the external world. The one-word verbal response just cited deprives the psychologist of this vital body of personality data released through the use of American Sign Language. The implications of this are clear for the use of projective testing where the interpretation of potentially limitless data hinges so much on the psychologist's linguistic skill in Ameslan. Additionally, not only is the psychologist's expressive fluency and fluency in receptive comprehension of Ameslan a must in the psychological testing of deaf persons, but also the psychologist's ability to "think deaf" is crucial in order that the deaf subject's expressive variations and deviations in response due to linguistic patterns can be separated from true personality responses. In view of all the foregoing, it is not very surprising that there had long been a test-produced as well as psychologist-produced stereotype of "the deaf personality." This well-known stereotype describes the deaf individual in more negative terms than the facts, if truth be known, warrant. Concerning the use of existing psychological measurements with deaf individuals, particularly when deaf persons are viewed as constituting a minority group, Erikson points out that tests may be offering "objective evidence" of ethnic differences, but may also be *symptomatic of them*. To quote him: "If this is totally overlooked . . . the test will only emphasize, and the tester will only report, and the reader of the report will only perceive the distance between [the minority group member's] 'disintegrated' self-imagery and what is assumed to be [the majority member's] 'integrated' one."

Therefore, then, probably even more important than the professional competencies — that's expected in all psychological practice — are the special competencies required in the psychological evaluation of deaf persons: (1) communication and (2) the use of the tests themselves. When counseling, interview, and therapy enter the psychologist's domain, the special competency of communication becomes critical. This is not to argue with the stance taken by some that, if given a choice, one should opt for professional over special competencies. One should certainly opt for, say, the surgeon known for his deftness in wielding a scalpel than for his skill in any communication, particu-

larly while one would be anaesthetically unconscious anyway. There is, however, no disputing the importance of this special competency in order to *at all* carry out the professional competencies in the area of mental health and deafness.

Congruent with the foregoing is the necessity now for taking a look at the tests themselves. Since the first translation of the Binet-Simon Intelligence Test into English, we can now see why psychologists should be interested in cross-cultural research. To argue the case for more culturally appropriate psychological testing for the deaf is also to argue for less ethnocentrism among the professionals in this field. For the past 40 years, many psychologists were captivated by the fascinating prospects of "culture-free" or "culture-fair" tests. At present, however, they agree after much research that it is impossible to develop a *lingua franca* among psychological tests. Focus is currently on the development of "culturally appropriate" tests or tasks, whereby a particular psychological dimension is assessed, according to Brislin, Lonner, and Thorndike, "by means of a medium familiar to the members of each culture." How, then, can existing tests best be extended to the deaf American culture? One practical and logical possibility would be to adopt a test "imported" from the hearing culture by means of translation into the appropriate medium: Ameslan.

To date, only one attempt to my knowledge has been made at a translation of a verbal test into sign language. Hoeman tested the accuracy of a group test as interpreted in sign language by an interpreter. The accuracy was found to be poor, but the results could not be explained by poor interpreting. The reason advanced for the poor showing is that the kind of signs used by the interpreter, while partially in Ameslan, were strongly influenced by the structure of the English used by the test administrator. Hoeman points out that any departure from preferred American Sign Language usage prompted by the English original may result in a translation that strikes the deaf person as awkward or garbled, just as a too-literal English translation of a foreign language results in unwieldy sentences, to which I add, to say nothing of bizarre meanings. To illustrate, consider the phrase from the French: "Il fait beau." An ethnocentric and literal translation would give rise to such senseless phrases as "It makes good" or "It makes beautiful." "Thinking French" and, by analogy, "thinking deaf," the translation then sensibly gives rise to "It's a beautiful day." In a pilot study done a few years ago, a research scale

requiring at least an eighth grade reading ability — therefore inappropriate for application to the segment of deaf subjects in my study — was translated into Ameslan on videotape. This translation was facilitated by the assistance of some of the members of the National Theater of the Deaf.

A subsequent reliability testing of this translated scale resulted in a reliability coefficient of .90.

In this connection, one American psychologist proposed in 1970 a test which would pinpoint a critical issue in cross-cultural testing. This is the BITCH test, an acronym that, in 1970, stood for "Black Intelligence Test Counterbalanced for Honkies" but now stands for "Black Intelligence Test of Cultural Homogeneity." The idea was to show that white Americans can be made to look pretty stupid when pitted against the norms developed on the black American subculture. This test, moreover, is in ebonized language which is referred to as the culturally appropriate verbal and nonverbal behavior of black Americans living within the United States and includes patois and dialects. Also, some test items ask the identity and authorship of persons or works culturally familiar to blacks. If a question asks for Washington's birth date, for instance, then April 5 would not be marked wrong: it is Booker T. Washington's birthday. At this point, perhaps, the proposal should be made for an analogous DITCH test: I'll let you figure this one out.

In closing, I would like to repeat that there is no mystery about the psychological testing of deaf people. Psychological tests, tasks, scales, and questionnaires are and have been translated into French, German, Spanish, and many other languages. Why not into American Sign Language also? As for the psychologist component of the testing situation, I can only suggest three alternatives for those psychologists who cannot or will not learn Ameslan. One, use skilled interpreters, but this is a highly dubious procedure, for results reported where an interpreter is involved do not meet high standards of validity. Two, wait for the day when tests have been translated into Ameslan, but that day will be a very long time hence. Third, say your "farewell" and leave the field of deafness. All in all, optimism is warranted for the future of professional psychology in the field of deafness. The Spartanburg Conference, to be published shortly, on the training of psychological service providers to the deaf is a good beginning. So, I end now by wishing you all a beautiful day.

TREATMENT OF THE DEAF CHILD IN THE SCHOOL SETTING

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Referral for treatment in a school setting springs from a conflict of values between the child and the educational system. Although children want to learn, teachers want to educate, and the educational system wants to administer effective programs, feelings of failure and distress are high. This remains so whether the subject matter stressed by the school is cognitive, affective, or moral-social. Laments at PTA meetings parallel findings of large-scale scientific surveys: neither academic nor behavioral objectives of the schools are being met adequately. Reading scores are falling; juvenile delinquency and feelings of "anomie" are rising.

Some children come to school with cognitive, motivational, and behavioral stances at odds with the environment of the school. Some teachers come to school with attitudinal stances at odds with individual children or groups of children. Children also come to school with congenital, prenatal, or perinatal insults leading to mental retardation and specific sensory or perceptual difficulties. Some children are prey to injury, illness, or nutritional deficiency leading to organic impairment. A vast number of children come to school from minority group environments that appear to affect their future cognitive achievement as well as their adjustment. The deaf child transcends all the above groups and may be a member of each. Historically, both World Wars have highlighted the fact that mental illness and emotional problems of crippling severity are widespread. Treatment within the school settings has become a major necessity (Berlin 1974).

Treatment can be conceptualized as a hierarchy of preventive endeavors. Prevention can be thought of on three levels. Tertiary prevention refers to the rehabilitation of children who have been diagnosed as having a definite psychiatric

disorder of some duration. The preventive aspect of this level is to reduce ineffective functioning at school, at work, within the family, and in interpersonal relationships. Prevention in this sense refers to intervention that forestalls continued or further malfunctioning. Secondary prevention refers to work with children with mild or incipient disorders. A major aspect of this work involves efforts at early identification of the disorder through prompt service or referral or both (Schlesinger and Meadow 1972). Primary prevention refers to "any specific biological, social, or psychological intervention which promotes or enhances mental and emotional robustness, or reduces the incidence or prevalence of learning and behavior disorders" (Bower 1965). Primary prevention thus focuses on the factors which lead to the sickness (Caplan 1965). Its goals can be the insurance of adequate physical and psychosocial, as well as social-cultural, supplies which avoid stress and increase the basic capacity to withstand future stress. It also promotes healthy ways of coping with life's difficulties. Prevention must take into consideration both the system and the individual. Attention needs to be paid to the adaptive potential of the individual and to the health-promoting abilities of the environment.

Ingredients of Prevention

Despite innumerable difficulties, attempts are being made to clarify the definition of mental health, life crises, mental disorder, prevalence figures, stability and intervention strategies.

Mental health. The following are characteristics of the mentally healthy child (Ringness 1968, ch. 12). (1) He is self-acceptant and has reasonably high self-esteem but recognizes his shortcomings and seeks to improve; (2) has a

realistic evaluation of himself and has reachable aspirations; (3) accepts responsibility for managing his life and making his own decisions; (4) is well balanced, flexible, and consistent in attitudes, goals, and ideals; (5) can withstand stress, tolerate some anxiety, and overcome the effects of trauma; (6) is able to relate well to others and has the good of society at heart; (7) seeks independence, autonomy, and self-actualization and is neither completely conforming nor completely selfish; and (8) attempts to solve his problems instead of either escaping them or excessively employing defense mechanisms.

Another definition perhaps more practical for school settings is that of Bower (1970, p. 349), who states: (1) A mentally healthy child is able to manage the symbols of our society. (2) He is able to cope with authority by dealing with rules, managing rapid and sometimes arbitrary changes in rules, and accepting the penalties for breaking rules. (3) He is able to live with peer groups, since part of the skill of dealing with rules is learning how to be an individual and yet function within the group. (4) He is able to regulate his emotions and manage his impulses. The ability to control one's impulses also includes the ability to loosen controls when appropriate and desirable. Inhibited behavior can be just as irrational in some contexts as impulsive behavior often seems to be. One can say that a mentally healthy individual has achieved an integrative balance between his emotional and rational capabilities.

Life crises. Human beings are prey to crises — developmental crises, i.e., the birth of a sibling; entering school; marriage; parenthood; and accidental crises, such as illness, death of a loved one, or natural and social disasters. A crisis changes the usual life supplies to the individual and provides him with a novel situation which may challenge him beyond his current capacity. A period of cognitive and emotional upset ensues, associated with confusion, rise of tension, anxiety, depression, anger, shame, guilt, and frustration. The most characteristic manifestation of a crisis is that it is self-terminating. Within a few days or weeks the tension dies down, the negative feelings dissipate, and the individual achieves a new equilibrium (Caplan 1965, p. 10).

Attempts have been made to predict from personality studies how individuals are likely to react during and after particular crises. It appears that external relationships with family and friends, professionals and nonprofessionals

deeply influence the outcome of any crisis situation. It is also noted that some individuals traverse a crisis successfully and achieve a reality-based, culturally acceptable pattern of adjustment and adaptation (Caplan 1961). Other individuals develop novel, but ineffectual, responses. Problems and issues are evaded or magical and regressive defenses are employed. These individuals emerge from the crisis less healthy and more prone to future disorder. Successful dealing with a crisis may be referred to as "coping," unsuccessful dealing as "defending." It is generally believed that *coping with* crises will enable an individual to emerge with more flexibility and greater behavioral alternatives; *defending against* problems usually leads to inflexible repetitive behavior patterns which may interfere with optimum resolution of the crisis and lead to future disorders.

Dealing with crises. Since it is known that the environment influences the outcome of a crisis, there are procedures which are calculated to do so more effectively. Crises which are predictable, such as the birth of a sibling or scheduled surgery, can be dealt with by anticipatory guidance, or "pre-worrying." It has been established that active worrying before the expected traumatic event will promote mastery of fear and frustration (Lindemann 1944; Janis 1958).

This psychiatric truism was most clearly elucidated for the author in an unpsychiatric setting. The Salzburg marionettes have in their repertoire a skit showing Wolfgang Amadeus Mozart providing anticipatory guidance to his sister, Nannerl, prior to a performance for the Queen Maria Theresa. Nannerl was describing her fear of failure and mortification should her performance go astray. The young Mozart tenderly took his sister in his arms and literally shook her while saying, "Tremble now and thou shalt tremble less later."

A number of crises occur without prior knowledge and cannot be anticipated. The entire field of crisis intervention is still relatively new but there are ways which appear to lead to a more successful outcome, ways in which an individual can attempt to deal with a crisis productively and mental health workers can intervene effectively. (1) Cognitively — the individual can be encouraged to confront the crisis situation actively by observing the problem, collecting information from his own past experience and from others with similar experience; he can be discouraged from any attempts to deny the crisis. (2) Affectively — the child can be encouraged to allow himself to feel and

express acceptably the negative feelings which the crisis provides rather than to suppress these feelings. (3) Socially or interpersonally — the child can be encouraged to master the feelings through interaction with a mental health worker and others of importance to him and to ask for help in dealing with his feelings and the material aspects of the task. At all times it is important to place the crisis in a realistic perspective and to avoid blind reassurance in order to free the child from the exaggeration of a fantasy life (Caplan 1965).

The helping environment. The helping environment of a normal child, a child in crisis, and an emotionally disturbed child consists of a number of adults and peers who at times themselves may need some help in coping with stress. A network of individuals can be provided to the child under stress. Berlin (1974) points out that nonprofessionals, parents, volunteers in a school setting and also children under supervision can provide effective help to children with learning and mental health problems. Counselors and psychologists in the schools can collaborate with community mental health professionals in establishing special programs for children at risk. As mental health experts move from the far-flung State hospitals and isolated psychiatric offices into the community, a revision of mental health tasks is taking place. Teachers are being assigned an essential role and may well become the prime agents in promoting mental health for school children.

Tasks to promote mental health by teachers. A number of tasks calculated to reduce stress are performed daily by teachers: (1) The life-space of the child can be modified by manipulating the school environment by altering the child's schedule, by changing his teacher or class temporarily or permanently, or by providing a quiet place for the child when under stress. Any modification should be preceded by explanation and preparation for the child. While the adult under stress is able to change his own environment more or less at will, the child is generally required to remain under stressful situations against his will. (2) Significant adults of the child's life can be involved and collaborated with. This may entail parent-teacher conferences to help the parent understand the child's pressures and to provide emotional support to the parents, who may themselves be under crisis. (3) Readjustment of peer contact — increasing or decreasing the frequency of association of encouraging or discouraging certain "pals" — is frequently used to ensure more optimal iden-

tification and modeling. (4) Techniques such as new teaching devices or careful behavior modification programs can be used to further success.

Mental health specialists believe that successful learning may best promote mental health. Redl and Wattenberg (1959) list four specific ways in which learning can assist development: (1) Learning builds and supports the child's feelings of self-worth; (2) learning can help to satisfy the needs for belonging; (3) learning builds confidence, which in turn increases the drive for further learning; and (4) achievement in learning helps the child to set realistic goals for himself.

Unfortunately, many disturbed youngsters have become very adept at defeating any programs devised for their treatment and at irritating their caretakers. When the above steps are unsuccessful, schools might consider obtaining consultation from a mental health expert who can help in early identification of serious emotional disturbance and can also help the teacher in devising other remediation strategies.

From crisis to disorder. If a crisis lasts longer than 4 to 6 weeks, it is probably a true emotional disorder, which represents a stabilized outcome of a crisis. The emotionally handicapped child will have one or more of the following characteristics: (1) an inability to learn which is not explained adequately by intellectual deficits, specific learning disabilities, physical difficulties, or differences in cultural or ethnic backgrounds; (2) an inability to achieve satisfactory social relationships with other children or adults and being unable to show warmth and sympathy toward others, to stand alone when necessary, to have close friends, or to be assertively constructive; (3) an inability to behave at a level commensurate with developmental status; (4) an inability to display confidence and belief in oneself or to overcome feelings of sadness; and (5) an inability to cope with stressful personal or school situations without developing fears, physical symptoms, or pains. Again it must be stated that the frequency, intensity, and duration of the behavior will need to be evaluated in order to determine if and to what extent maladjustment exists (Bower 1970).

Prevalence of behavior disorders in "hearing" school populations. Prevalence figures for emotional disorders are elusive because estimates vary with the definition, the agency sampled (school, guidance programs, or hospital), and the identification methods employed (referrals to specialists, rating scales, self-report inventories and sociograms). A review of 27 studies between

1935 and 1967 (Glidewell and Swallow 1968) indicates that 30 percent of elementary school youths show at least mild adjustment problems, 10 percent are in need of professional clinical assistance, and 4 percent would be hospitalized if such facilities were available. These findings are consistent with those reported by Bower (1960) in that they too indicate that three youngsters in the average classroom (10 percent) have moderate-to-severe mental health problems.

Several factors are related to the prevalence figures of emotional disorders: (1) There is considerable evidence to show that educational maladjustment is associated with personal maladjustment in school-aged children. Finding a close relationship between the two is expected for at least two reasons (Craig, Mehrens, and Clarizio 1975): (a) Accomplishment in school-related activities constitutes perhaps a major developmental task of youth in our society. (b) School maladjustment and personal maladjustment have many common determinants, such as low intelligence, low socioeconomic status, poor peer relations, and a variety of ego factors (i.e., distractibility and an inability to delay reward). (2) There is a correlation between sex differences and adjustment. Emotional disturbance in children is reported to be primarily a male phenomenon, although in adulthood more females seek help. For every three boys labeled maladjusted by teachers, there is only one girl so labeled. School adjustment difficulties for boys typically center around problems of acceptance of authority, concentration, cognitive achievement, and speech and reading skills (Glidewell and Swallow 1968). (3) Other factors are socioeconomic status, race, and age. "Data based on 579 of 682 clinics in 25 States indicate that nonwhite rates of disturbance are higher during most of adolescence and adulthood, although lower in early childhood (ages 3 to 11) except for mental deficiency. Moreover, nonwhites tend to be seen for more serious disorders" (Craig et al. 1975, p. 353). The highest percentage of emotionally handicapped students is in the elementary and junior high grades, with the lowest percentage of emotionally handicapped children in the early primary and later high school grades (Bower 1961). Nevertheless, the age differences in the prevalence of maladjustment may not be so great. Glidewell and Swallow (1968) report that many of the problems seen in kindergarteners are viewed with more tolerance, accounting for the lower prevalence figures, and the lower referral rates during the adolescent years may be related to the fact that many students with a long

history of maladjustment drop out of school and are lost for prevalence figures.

Relationship of school maladjustment to later functioning. No clear-cut relationship seems to exist between early disturbance and later functioning. Some studies indicate that the label of emotional disturbance stays with a youngster for many years, whereas other studies remark on a one-time labelling (Craig et al. 1975). Nevertheless, analyzing the above studies, these same authors feel that about 30 percent of disturbed children will continue to have moderate-to-severe problems as adults. Many investigators have commented upon the fact that the stability of deviant behavior depends on the child's environment. Some early childhood symptoms will not be troublesome in adulthood, as the adult is more and more able to forge his own environment (i.e., dependent adults may be able to find nurturant bosses and spouses). Early childhood symptoms of aggressive antisocial and acting-out behavior most predictive for later disturbances may be most deserving of treatment efforts (Roff 1961).

The Deaf Child in the School Setting

Of interest in this paper is the deaf child in the school setting and the specific treatment of his emotional disorders. Therein lies a rub. Words need clarification, and consideration needs to be given to the myriad of potential variables which sharply affect the developmental or life crises of the deaf child. Throughout his development, the deaf child has been found to exhibit characteristics of rigidity, egocentricity, absence of creativity, decrease or lack of empathy and inner controls, suggestibility (summarized by Meadow 1975), and impulsivity (Altshuler et al. 1976) as well as a marked decrease in linguistic competence and performance (summarized by Schlesinger, in press). Curiously, the deaf child has been studied without clear delineation of a number of variables that markedly affect the character of the handicap. More recently, however, studies have been forthcoming with more specific attention to such variables as the etiology, extent, shape, and onset of the hearing loss; hearing aid usage; parental hearing status, parental involvement; and the school environment.

Prevalence of disturbance among deaf children. Again, incidence and prevalence studies are complicated by ambiguous definitions and by varying reporting systems. Large scale questionnaires, such as the Annual Survey of Hearing

Impaired Children and Youth (Jensema and Trybus 1975), tend to report maladjustment incidence figures around 10 percent of the school populations. Surveys of smaller populations with more intensive recording report much higher prevalence figures. For example, 11.6 percent of children in a residential school were reported to be in need of psychiatric treatment and another 19.6 percent were described as taking a disproportionate amount of their caretakers' time, compared to 2.4 and 7.3 percent for hearing children (Schlesinger and Meadow 1972). Freeman, Malkin, and Hastings (1975), surveying the 120 hearing-impaired children in the greater Vancouver area of British Columbia, report 22.6 percent demonstrating moderate or severe disorders. Altskuler (1975) notes that only one-third of the 40 children he was asked to evaluate had been reported as disturbed on a large-scale survey. Furthermore, there is some indication that a significant number of deaf children are floating about disconnected from any psycho-social support from the school system. Schein (1975) indicates that in one school system nearly 10 percent of eligible school children were at home, and Vernon (1969) points out that 9 percent of 390 youngsters in one school system were excluded because of severe emotional problems. A representative of the Bureau of Education of the Handicapped reports that 40 percent of all handicapped children of school age are not attending school at the present time (Behrens, Note 1). Meadow and Schlesinger (1976) have summarized nine prevalence reports with figures ranging from 7.9 percent to 41.7 percent.

Factors related to prevalence figures of emotional disturbance among deaf children. The description of the normal child and the deaf child in crisis leads to a description of the prevalence figures of and factors related to emotional disturbance among deaf children. (1) Etiology — Knowledge of the etiology of the deafness seems to be important for several reasons. Of the five major causes of early childhood deafness, four are also major etiological factors in brain damage: Rh incompatibility, rubella, prematurity, and meningitis (Vernon 1968). Researchers disagree about the incidence of disturbance — organic brain damage or behavioral disorders — among rubella children. Higher prevalence figures appear to be related to uncertainty about etiology with the possible concomitants of parental guilt and differential treatment. At a residential school, 55 percent of

the youngsters identified as emotionally disturbed were reported to have "etiology unknown," and in a longitudinal study all six youngsters with deafness of an unknown origin were referred for psychiatric help (Meadow and Schlesinger 1976). (2) School environment — The school environment for the deaf child varies greatly. Some deaf children are in special classes and others are in day or residential schools for the deaf. Each seems to have its own strengths and its own particular problems. Reviews from 20 to 40 years ago (Barker et al. 1953) suggest that residential schools for the deaf are "not optimal environments for the development of social maturity." More recently, Quigley and Frisina (1961) conclude that their data provide no evidence that living in a residential school is detrimental to deaf children in terms of educational achievement and psycho-social adjustment. It must be remembered that residential schools today are very different from those of several decades ago, and their environment is more health promoting. (3) Parental hearing status — A number of studies (summarized in Schlesinger and Meadow 1972) indicate that deaf children of deaf parents (and in residential schools, since few deaf parents send their children to day schools) rate highest on a number of characteristics postulated to be involved with "positive mental health." They have significantly higher scores on tests of self-image, on adjustment to deafness, communicative confidence, and assessment of the attitudes of hearing people toward themselves. They also rate higher on items such as maturity, responsibility, independence, sociability, and popularity with peers. Deaf children whose parents are hearing and who attend day schools exceed deaf children of deaf parents only on the criterion of appropriate sex-role behavior. Other deaf children whose parents are hearing but who attend a residential school have significantly lower scores on all of the above criteria with the exception of adjustment to deafness, on which they are intermediate between the other two groups. Almost similar findings and group standings exist for cognitive achievement. (4) Communication abilities — The relationship of communicative competence and behavioral problems is complex, as was suggested in the comparisons of the children of deaf and of hearing parents. In a longitudinal study of 40 deaf children with hearing parents, specific behavioral difficulties were assessed. Communicative ability was related to fewer behavioral disorders; the correlation between a behavior

checklist score and the Word Intelligibility by Picture Identification Test was $-.42$ ($p < .01$), (Meadow and Schlesinger 1975).

Secondary Prevention

How can disorders among deaf children be prevented, and how can secondary prevention be provided within the school system? To review, secondary prevention refers to early identification and treatment of incipient disorders. We can point with gratification to three children demonstrating successful secondary prevention.

Jessica. When first seen, Jessica was a tiny tot of 27 months who flitted from place to place, often perilously, while her paralyzed parents were helplessly sitting by. Because she had a history of traumatic birth followed by neonatal infection, her parents were expecting the worst for her future development. The diagnosis of deafness was delayed while the audiologists were testing; intervention was similarly delayed, and the mother felt frantic. The father felt proud of his seeming insouciance. The youngster apparently was permitted to rule the roost, since the mother felt "a poor, handicapped child cannot be asked to live up to normal expectations of behavior." Thus, when Jessica walked up and down the dining room table, not a "no" was spoken, not a frown was shown; nor was she picked up and firmly placed back on more acceptable surfaces. The teacher who observed this behavior was quick to show by her actions that a deaf child also can be expected to pay attention and to learn the rules of civilized living. Slowly and painfully the parents followed suit.

A number of older youngsters had a similar history of parental paralysis and indicated by their later behavior that the rules of living were incomprehensible to them. Their behavior became more and more unacceptable as they moved from the younger, cute years to the older, more annoying years. In Jessica's case, the intervention occurred at a time when the behavioral deviations could be changed more easily.

Jonathan. The son of mental health professionals, Jonathan was an engaging-looking child seen as severely disturbed by his parents and by the child psychiatrist who was seeing the family in treatment. His symptoms ranged from muteness and eye avoidance to obsessive closing of doors and playing with light switches. He was felt by the parents to be negative and obstinate. He showed some improvement in play therapy,

but his muteness continued unabated. When, upon suggestion, his hearing was tested, he was found to have a profound hearing loss. Due to the imminent departure of the family from the area, a massive educational intervention was planned for a 3 month period. The planning included parental support on a group basis, hearing aids, and sign language lessons for the parents and child.

Communication, which had been nearly non-existent and was characterized by the child's muteness accompanied by minimal attempts to communicate by gestures and which was in turn rejected by the parents, began to flourish. The parents, freed from their expectations for immediate speech, relaxed their urgent insistence, but maintained their expectations for dyadic communication in both sign and speech modalities. The parents and the child improved dramatically. Although Jonathan's behavioral problems had started to diminish during the 6 months of therapy prior to the diagnosis of deafness, improvement accelerated following the diagnosis and the measures of intervention. It may well be that the youngster's attempt to communicate in gestures was firmly understood and accepted by his parents, an event that relieved the communicative frustration and reduced subsequent behavioral deviations.

Bruce. An adopted child who had been identified as an "enfant terrible" by an entire school system, Bruce was seen as destructive, unmanageable, and unable to learn. Therapy with the parents and child very quickly showed marked improvement in the home setting. However, the difficulties within the school remained. Attempts made to involve the school personnel were to no avail. This was the only referral which necessitated a change of schools before the child was able to settle down and relinquish his symptoms.

Without intervention these three youngsters would have been on an inexorable road toward psychiatric disorder requiring tertiary prevention.

Tertiary Prevention

To repeat, tertiary prevention refers to the rehabilitation of patients who have been diagnosed as having a definite psychiatric disorder of some duration. The diagnostic categories (Schlesinger and Meadow 1972) run the gamut of psychoses, neuroses, personality disorders, transient situational-reaction and behavior disorders. This last category was clearly the largest (27 percent) and had within it two peaks repre-

sented by withdrawal reaction and unsocialized aggressive behavior patterns. The treatment of these disturbed deaf youngsters has had exciting results on the one hand and tragic results on the other. Favorable shifts, as noted by positive behavioral and situational changes, occurred in 75 percent of the cases. The tragedy is that at no time has there been sufficient staff to provide adequate services. (This paucity of services will be discussed subsequently.) Examples of tertiary prevention follow. In conjunction with the cases of secondary prevention, they illustrate specific aspects and difficulties associated with providing therapy to deaf children and adolescents.

Susan. A 6-year old youngster of high intellectual potential, Susan has been seriously disturbed since early infancy. One of premature twins, she had a stormy postnatal period. Her physical development has been normal, except for mild visual problems and a moderate hearing loss. Her family background is somewhat chaotic; she lives in a one-parent household with several siblings, both older and younger. Her initial psychiatric symptoms were severe — echolalia, obsessive-compulsive rituals, temper tantrums and eye avoidance techniques. She was a school expulsee at 6. The first 2 years of therapy were characterized by frantic attempts by her mother and the therapist to obtain appropriate school placement. Finally a class for emotionally disturbed deaf children was initiated in a private school. Mental health consultation and sign language classes were provided. Her progress has been slow but consistent in both cognitive and affective realms.

Brenda. A highly endowed deaf adolescent, Brenda succumbed to a psychotic break. Again, crisis intervention time was spent in seeking a hospital setting for a moratorium. A deaf patient is isolated from therapeutic activities unless communication through sign language is available from the staff. Effective inpatient settings have centralized their deaf patients with staff equipped with specialized skills (Edelstein 1976; Goulder 1976).

Therapy with deaf children. Therapy with deaf children is characterized by the following:

(1) *Involvement with numerous agencies.* Paradoxically, this involvement is frequently counterproductive because of additional pressure on family members due to innumerable proscriptions and prescriptions; frequent competitions and conflicts between agencies; lack of coordination among agencies; and lack of adequate involvement of crucial agencies, adequate in terms of dealing with the communicative

problems between the deaf client and agency personnel. Crucial agencies may be hospitals, schools, churches, youth organizations, rehabilitation centers or welfare departments. The situation is improving due to the better training of staff and the greater availability of interpreters through the Registry of Interpreters for the Deaf. Another detriment is the shock-withdrawal-paralysis reaction of professionals when dealing with deaf clients. For example, law enforcement agencies typically over or under-punish deaf offenders.

(2) *Paucity of adequate mental health services stressing existing facilities.* Historically, problems of the deaf have been delegated to or adopted first of all by the church and later by the fields of education and rehabilitation. Mental health as a profession has been a late comer to the scene. Funding for services has also been a problem. Deaf children who have the additional burden of emotional disturbance have fallen between the slots of the bureaucratic funding system. Furthermore, Federal demonstrations projects cease, and State budgets are tight. In order to keep a community mental health center viable, or even hobbling along, much professional time is spent in fundraising, grant-writing, and community organization. A recent exciting event has been the involvement of the deaf in fighting for funds for mental health services for their community. It would appear that unless a more clear-cut funding pattern emerges, mental health services for the deaf will remain a stepchild in the psychiatric and mental health fields.

(3) *Infancy of the field.* The field of mental health services for the deaf is still relatively new. Most of the 17 centers extant today are still in their infancy; only four centers have existed for 10 years or more. The usual paucity of trained mental health professionals is further compounded by the necessity of prolonged training and specific expertise. The mental health professional needs to have thorough knowledge of the developmental vicissitudes resultant from deafness and needs to have at least a minimum of competence in the varying communication systems used among deaf children, teens, and adults. (For more information about sign language usage, see Bornstein 1973.) Due to the paucity of professionals with knowledge about deafness and manual communication as well as knowledge about mental health, some professionals insufficiently trained in one of the above two areas have entered the field. The deaf individual suffers. Sign language competency does not replace mental health knowledge; nor

does mental health knowledge replace sign language competency and knowledge about deafness.

(4) *Specific communication problems.* Beyond the fact that most adult deaf patients require sign language for therapy (Rainer, Altshuler, and Kallman 1963), children represent yet another problem. A large number of young deaf children, and a yet larger number of disturbed deaf children, are not proficient in either sign language or spoken English. Communication with some youngsters can proceed only through nonverbal means — pantomime, gestures, puppets, and pictures. Although play therapy with hearing youngsters has a large nonverbal component, the therapist is able to "comment" and "interpret" via verbal language, body language, and affective responses. The unavailability of verbal skills requires that the therapist make himself clearly understood without words. Imagine preparing a child for a therapist's vacation via pictures only! Most older children do have verbal language, although frequently no spoken language. The therapist frequently is the one who cannot communicate, a stance difficult for therapists who rely on words.

At any level of communicative ability, therapist and patient need to have eye-to-eye or eye-to-face contact. Patients have been known to use eye avoidance and to accelerate the speed of signing as controlling mechanisms. The therapist again finds himself in a dilemma. Children in play therapy are usually told that they may do anything except hurt themselves, others, or objects in the room. But what about eye closure? A hearing child will hear "I guess you don't want to pay attention to me now and that's okay." However, this very permissive but cognitively structured and unambiguous statement cannot be received by a deaf child with eyes closed. The therapist's choice is between silent, possibly ambiguous attentiveness of the clearly intrusive maneuver of touching or poking, hoping that eyes will pop open. Deaf children characteristically have "intrusive" mothers (Schlesinger and Meadow 1972) and will object strenuously or passively to such maneuvers from the therapist. Further research is needed to study the ambiguity of a message between nonsymbolic communicators — be it the therapist without sign language or the child without speech.

Primary Prevention Revisited

Primary prevention may also be conceptualized as ensuring "those aspects of man's experi-

ence which give him the maximum ability to adapt to his own potential as well as to the realities of his environment" (Bower 1965, p. 4). The goals of primary prevention would be to diminish the need for secondary or tertiary help.

Successful deaf adults (successful in terms of psychological health — adaptation and self-actualization) use more coping mechanisms than defense mechanisms and are also superior academically, having had successful, early, meaningful, and enjoyable parent-child linguistic interactions. Heretofore successful deaf adults tended to have a greater degree of residual hearing, a later onset of the hearing loss, or to have deaf parents. We are postulating that under certain circumstances deaf children can in increasing numbers become more successful even with a greater hearing loss, an earlier onset of deafness, and with hearing parents. This can occur either by diminishing the commonly hazardous circumstances or by increasing enhancing life experiences.

What are the commonly hazardous circumstances that impinge on the majority of deaf individuals throughout their lifespan and which may diminish enhancing life experiences? How are the physical, psycho-social, and social-cultural supplies postulated to be essential to good mental health affected by the deafness? Further research is needed, but haunting themes occur throughout our clinical and research work. It would appear that deaf individuals encounter throughout their lifespan significant figures who view them with distress, with ignorance, with conflict, with "attitudinal apartheid" or with distorted expectations.

(1) *Distress:* Distress may be seen as the prevalent feeling of most hearing parents upon the diagnosis of deafness. Distress may be about the deficit, fear about the future, or distress about possible guilt. Unless this distress is faced and worked through early, feelings will persist and affect the child and parent continuously.

(2) *Ignorance:* Society still has a paucity of knowledge about deafness, and there is still a general lack of information about deafness among physicians. During the critical diagnostic period, many parents report a lack of support from the medical profession characterized by misdiagnosis, false reassurance, or distorted and delayed treatment plans.

(3) *Conflict:* Conflicting advice from experts due to a centuries-old battle regarding the optimal education of the deaf robs the parents of support and can precipitate a prolonged conflict (Schlesinger and Meadow 1972).

(4) "Attitudinal apartheid" (Edwards 1973): This term, devised to connote the pervasive dilemma of the black American vis-à-vis the majority culture, is almost equally applicable to the deaf individual. A self-concept affected by oppression based upon race or deficit may produce cultural deprivation and isolation with a devastating effect upon the learning process. Cultural isolates achieve markedly below their innate learning capabilities. The isolation may be most felt in terms not of physical but of psychological barriers. History of failure at school may promote further failure. Ego-impairment figures prominently among the several causes of underachievement, and a true assessment of intellectual capacity is practically impossible because lack of stimulation tends to impair intellectual functioning (Edwards 1973). Also "our meager instruments are inadequate in our attempts to assess the intellectual capacity or the cognitive functioning of culturally different children. We must assume a normal distribution of mental ability within this group and then set about to supplement what they have already learned with experiences, concepts, and language learnings that will facilitate their cultural transition and allow them to become cultural straddlers" (Edwards 1973, p. 195).

Versatile cultural straddling, or living in both worlds, is somewhat different for the black and for the deaf child. The black child comes from a black culture, but the deaf child for the most part is born to a hearing culture. Abandoning either culture may lead to feelings of anxiety and guilt or fear of rejection. Again, Edwards (1973, p. 197) suggests, "In working with teachers of culturally different children this writer constantly makes the plea that children be helped gently and skillfully to become cultural straddlers. In essence, this involves their developing a kind of cultural versatility that allows them to move freely and selectively back and forth between their native culture and that of the mainstream within the society. This is not an idle plea, since there are countless examples of individuals who are very effective and comfortable as cultural straddlers." It would seem obvious that cultural straddling is a very different concept from unilateral mainstreaming.

(5) Distorted expectations: Teachers of deaf children are frequently not clear about the achievement potential of their deaf students. This is even more true when the students are disturbed. False expectations in either direction rob the teachers of a sense of competence. Maladjusted students and their parents often be-

come the charges of teachers ill trained to cope with the additional problems. If the environment which impinges on the deaf child is to be therapeutic, teachers too must feel comfortable. They need assistance with the maladjusted students, help with the parents, and relief from nonteaching chores (Craig et al. 1975).

Summary

Prevention and treatment of disturbances are crucial for the deaf child in a school setting. Preventive maneuvers stress the relationship between the child and his environment. Support given at a time of crisis can prevent the occurrence of future disorder. Additional stresses imposed by deafness may require additional support for the deaf child and those in contact with him. Differences in the communicative stance between the deaf child and his environment require special communicative expertise. In decreasing hazardous circumstances and enhancing life experiences, communication can be made more reciprocal and less ambiguous and identities more inclusive. Early intervention both lessens the need for treatment and increases the opportunities for deaf children to find ways toward greater achievement and happiness.

Reference Note

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PREVENTIVE MENTAL HEALTH SERVICES IN THE DEAF COMMUNITY

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This talk focuses on my own experience in a preventive mental health service program at the Maimonides Hospital Community Mental Health Center, an experience which I would like to share with you as a stimulus to your own thinking and planning.

This service program was begun on a very modest scale by Dr. David Farber, a recently deafened psychiatrist, and functioned as one of the various departments of the community mental health center, with the one special proviso that it could serve deaf people from all over New York City, whereas the other services of the center were limited to residents of a specific geographical portion of the city. Unfortunately, Dr. Farber died not long after starting the program. In order to keep the center's program functioning, Dr. Euna S. Levine sent me and one other doctoral student from New York University to Maimonides. By 1972 the program grew to a full-time operation with basically outpatient services: individual counseling and psychotherapy, parent counseling, and psychological and psychiatric evaluation. We did a lot of counseling with persons referred by the Department of Vocational Rehabilitation, especially with those who had difficulty staying on the job.

The staff was then composed of myself and another psychologist. Then we added a consulting psychiatrist. Subsequently, a crisis intervention program was initiated. As we grew, our services expanded to include group psychotherapy and diagnostic and treatment services for children, including play therapy. A psychiatric social worker from the community mental health center joined us. The Director of Clinical

Services himself grew interested in our program and began to serve as our supervisor. We began to feel less and less alone, as more and more of the general clinical staff became interested and involved in our program.

As time went on, our patient load snowballed, and we had much more than we could handle. Our patients were children, adolescents, adults of all ages, and parents. Interestingly, 75 percent of all our patients were self-referred, and many others were referred by friends. We never really had to "advertise" our services, since deaf people heard about us by word of mouth, or through the "deaf grapevine," if you will. Before long we added practicum and internship students to help us out. Our service schedule had expanded from 1 day a week to 2 days, then 3 days, then to full time.

Or so we thought: "full" time. We realized before long that we needed "full time plus." Family therapy especially provided the impetus for this further expansion into evening hours, for we could snare the elusive fathers who always "couldn't come because I'm working." Once we added the evening hours the fathers changed the tune to, "Who's going to babysit the kids?" Our reply was, "Oh, we have babysitting services in the playroom downstairs, and the babysitter is a mature, professional mother." Referrals began to come from the schools — all the schools: oral schools, schools using sign language, and those employing a combined method. With these school referrals our family therapy practice grew, and we knew that our staff needed more intensive training in family therapy. Fortunately, in the same building which housed the mental health center there were a number of family

therapists, who agreed to provide us with formal training and supervision in family therapy, and who also met with our deaf families to help us out.

We added a group psychotherapy program and expanded into crisis intervention services. I personally experimented with group counseling for deaf children who were "integrated" into regular classrooms with hearing children and found it to be one of my most successful groups. We had psychotherapy groups for multiply handicapped deaf adults. We established counseling for parents of deaf children, and marriage and divorce counseling. We had what we called "couples counseling" which was not limited to husbands and wives, but included as well men and women who were simply living together, and homosexual partners.

Working with deaf children and their parents in child abuse cases brought us into contact with the law enforcement agencies and made us keenly aware of a surprising number of deaf children who had been cruelly treated by their parents. Drug-related problems brought a number of deaf people to us, including 12-, 13-, and 14-year-old deaf pill-poppers.

The staff of the medical center worked closely with us when we needed a neurological examination, an electroencephalogram, or other medical procedures, and they did not hesitate to demand equal time from us when, for example, they needed assistance with deaf patients in the emergency room. More than a few times we found ourselves out of bed and racing across town at 3 o'clock in the morning to interpret in the emergency room, or to try to talk a deaf person out of jumping off the roof of his apartment building.

So while we were a small staff, we made good use of the larger staff of the mental health center. Our practicum and internship students, who were fluent in sign language, offered sign language instruction to psychologists, psychiatrists, social workers, and other staff members. We made a special point of teaching the secretaries and receptionists for the sake of that all-important communication at the point of entry into the center. A big plus was the inclusion of our staff in the center's inservice training programs, which were conducted on a large scale. It was an unwritten rule that everyone, with or without Ph.D. or M.D. or other degrees, was expected to give 10-15 percent of his time each week to inservice training.

Another important issue is the attitude of deaf people toward mental health services. Pub-

lic education about mental health services and the reputation of the particular center and its staff members were key ingredients: Deaf people will go where they can get quality services. Our caseload was small when we started, but word travels quickly in the deaf community and we soon had more business than we could handle. The deaf community was not at all reticent about applying its own consumer rating system: "thumbs up" to this person, this place, and "thumbs down" to that other one.

We began to wonder if we had gone too far in our relations with the deaf community. At first, deaf people would rather be caught dead than seen going into our center, or they would ask where the back door was. Later we would find groups of deaf people socializing in the waiting rooms, and boyfriends would pick up girlfriends at the conclusion of their therapy session. One time the Tuesday Evening Bowling League waited in the main lobby for one of their members to finish a therapy session so they could go in strength to a tournament. The mental health stigma was no more.

Of course, we became involved in public education. We attended the social, civic, and recreational functions of the deaf community and spoke on preventive mental health at their meetings. With general audiences we would often say, "What if you have a pain in your tooth? It hurts. What do you do? Do you let it become worse, become infected? You go to a dentist, or maybe you would lose the tooth. Right? Right. The dentist fixes that tooth and you save it. The same with your mind. You are troubled. Go to a mind doctor before you lose it!" Neither the humor nor the message missed its mark.

When we requested funds for expansion of the staff, the center administration agreed that the request was justified; that the demand for services was there; and that the deaf clientele paid for their services, on a sliding scale, as did the other users of the center's services. But you all know what the funding picture has been, and so the program has remained small.

We served mainly deaf children and adults who were not sick enough for the hospital and tried to keep them out of the hospital. They represent the vast majority of the deaf population. I want to share with you my concern that our approach in mental health services for deaf people is a bit misdirected. When we focus on institutional programs we are neglecting the vast majority of deaf people who need outpatient services, not inpatient beds. Call this a plea for preventive

mental health services. I am talking about deaf people with everyday problems, with mild neuroses, situational reaction problems, children having difficulty relating to their parents, and so on. The idea is to nip these problems in the bud, before they erupt into more serious disorders.

We offered a preventive mental health service

program to deaf children, deaf adults, and their families. The response, after a slow start, was overwhelming. What I would like to see is an expansion of mental health service programs for deaf people in two directions: inpatient services, and especially, outpatient preventive mental health services within the community.

A COLLABORATIVE RESEARCH NETWORK AMONG MENTAL HEALTH SERVICES FOR DEAF PEOPLE

Raymond J. Trybus, Ph.D.

My purpose here is to submit to you a proposal for a coordinated national data and research system, linking all the mental health services for the deaf in hospitals and clinics, as well as the various school-based programs for emotionally disturbed deaf children, so as to produce a pool of information large enough to enable us to pursue some significant research, program evaluation, and "state-of-the-art" reporting projects, which would not otherwise be possible.

Before this proposal can make much sense, you should know something about the Office of Demographic Studies, which I represent. The need for accurate and reliable data on the hearing impaired population of the United States has long been a concern of those working in the field of deafness. In 1964 a "Conference on the Collection of Statistics of Severe Hearing Impairments and Deafness" was convened by the National Institute of Neurological Diseases and Blindness (now known as the National Institute of Neurological and Communicative Disorders and Stroke) at its Bethesda headquarters. Briefly put, the participants in that conference agreed that although comprehensive and accurate information was needed for many purposes, such information was not then available. Accordingly, they recommended that the Federal Government establish appropriate channels for the collection, analysis, and dissemination of such national statistical information. Two projects resulted from these recommendations, the first of which was the Annual Survey of Hearing Impaired Children and Youth, at the Office of Demographic Studies of Gallaudet College. This was established as a pilot project in 1966 and was expanded to a permanent, national operation in 1968, with the mission of providing relevant statistical information on hearing impaired per-

sons from birth through college age. The second project resulting from that 1964 conference was the National Census of the Deaf Population, which was to be a one-time project to determine the numbers and major characteristics of the deaf population of the United States. This census was supported by a Federal Grant to the National Association of the Deaf, which conducted the census in collaboration with the New York University Deafness Research and Training Center. The report of this project was published last year.

What does the Annual Survey do? Every year we contact the approximately 1,000 programs which offer special educational services to hearing impaired children (ranging from residential schools for the deaf to integrated classes and itinerant programs in the regular public schools) and ask them to submit a variety of information on each of their students. Participation in the Survey is voluntary, and we now receive data on about 80 percent of the total national enrollment. In the 1975-76 school year, for example, we collected information on 50,000 hearing impaired children, including such items as age, sex, race, type of educational program, cause of hearing loss, age at onset of hearing loss, audiometric test results, and additional handicapping conditions beyond the hearing loss. These basic items are supplemented from time to time with other items of national interest as determined by our National Advisory Committee. The O.D.S. has also been involved in extensive studies of the educational achievement of hearing impaired children and has produced and nationally standardized a Special Edition for Hearing Impaired Students of the 1973 Stanford Achievement Test. But what we collect is only the beginning.

What happens to the data which are collected? First, the results are published in a series of

statistical and reference monographs, research bulletins, and journal articles in order to make these national figures available for general knowledge and program planning at the national level. The maintenance of such a large data base makes it possible to uncover a variety of significant facts, such as that presented in Figure 1, showing that the month-of-birth pattern for children who are deaf because of rubella is strikingly different from that for the general population. This preponderance of rubella births in October, November, December, and January clearly supports the medical epidemiological finding of highest rubella prevalence in the spring, when these winter babies were conceived.

Here are some other findings of special interest to this group. A few years back we collected nonverbal IQ test scores on more than 21,000 hearing impaired children. Figures 2 and 3 show two particularly interesting findings. First, children with two deaf parents have a clear advantage, with a mean IQ score of 107. Deaf children with hearing parents average about 96 on the same tests. This, of course, is a national confirmation of a finding reported by others in smaller scale studies. Figure 3 shows the relationship of IQ of the deaf child to the number of siblings in the family. You can see that children with two siblings do the best, and that the trend is consistently downward beyond that, with a mean IQ score of about 89 for those deaf children who have 8 or more siblings.

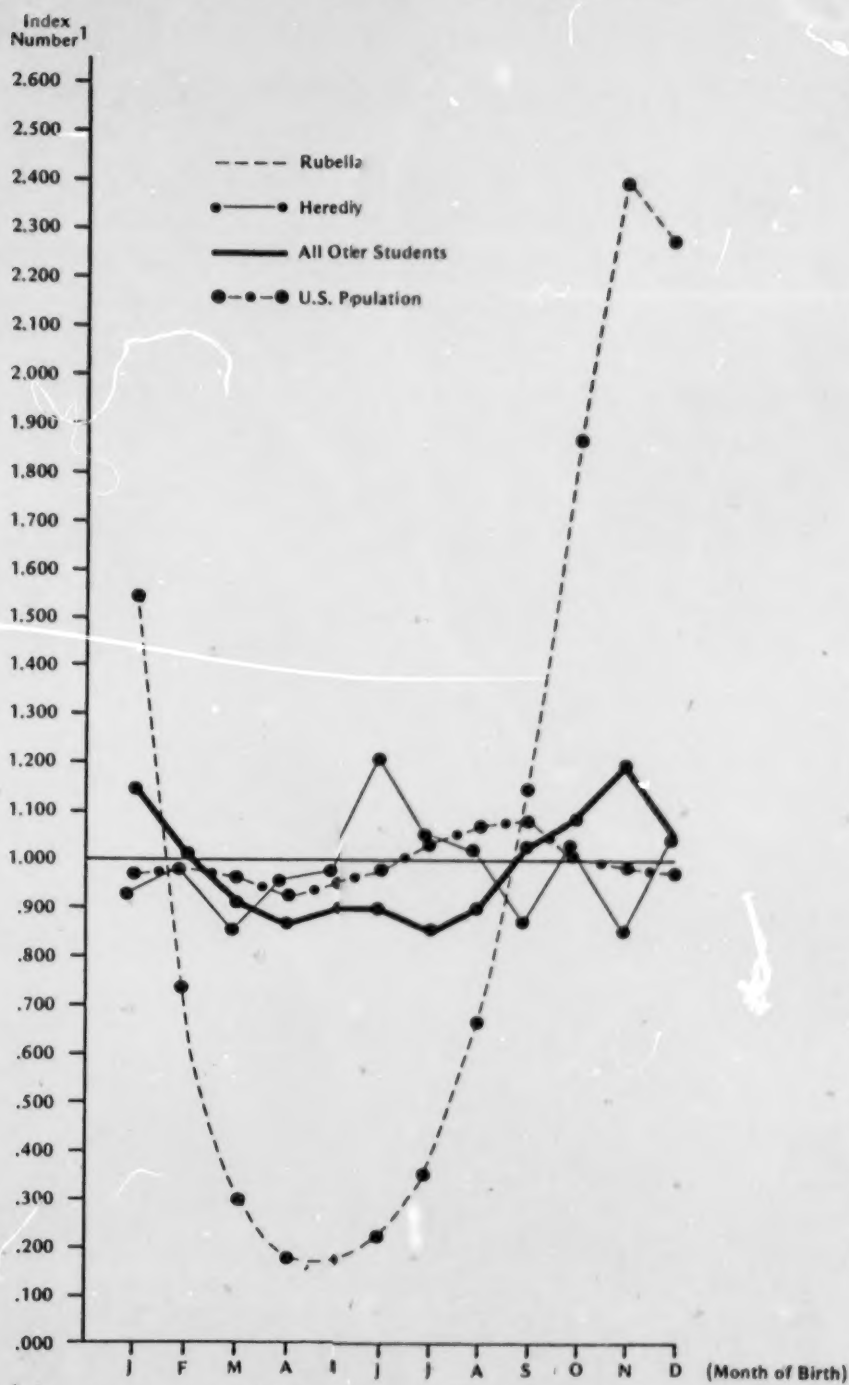
Our studies of reported emotional/behavioral disturbances have produced some interesting results. One is that the rate of emotional/behavioral problems is much less for the deaf children of deaf parents (about 5 percent) than for deaf children of hearing parents (almost 10 percent). We also inquired as to who made the determination that the child was emotionally disturbed and whether or not medication was prescribed as a result. About half of the diagnoses were made by physicians (17 percent) or psychologists (31 percent); the remainder were diagnosed by teachers or other personnel. Physicians and psychologists gave very similar ratings of severity (18 percent and 19 percent respectively, labelled "severe" rather than "moderate" or "mild"), while teachers and other diagnosticians assigned lower proportions of "severe" ratings (12 percent and 8 percent respectively). On the question of medications, however, some very large differences emerged. Of those children diagnosed as emotionally disturbed by physicians, 59 percent were receiving some medication as a result. When a psychologist was

the diagnostician, only 20 percent were receiving medications, even though psychologists gave slightly more severe ratings to those they diagnosed. If a teacher or other person was the diagnostician, only 12 percent of the children were receiving medications; this difference cannot be ascribed solely to the lesser severity ratings assigned by these individuals. Clearly, there are some important questions here, deserving of further investigation on a large scale. To repeat, then, publication of findings such as these is the first use made of the national data which are collected.

Secondly, special reports are prepared for each school and each State which participate in the Survey, allowing that school or State to compare the characteristics of their deaf children to those of deaf children in the Nation as a whole, or in a particular geographic region of the country, or to children in similar types of school programs, and so on. For example, a comparison of this sort indicates that 26 percent of the deaf children in Texas come from Spanish-American families, compared with 7 percent for the United States as a whole. This makes it clear to State-wide program planners that there is a much greater need in Texas than elsewhere for teachers who are familiar with the Spanish language and culture, as well as for curriculum materials suitable for children from Spanish backgrounds. This knowledge can then be translated into teacher recruitment and hiring policies and into funding requests to the State legislature and perhaps to the Federal Government under the Bilingual Education Act. Some reports of this sort are prepared routinely for all participating schools, others are tailor-made on request. A related function involves collaborative research between the O.D.S. and other researchers who wish to investigate relationships within this national data base, or who wish to relate their findings to the characteristics of the children, or who wish to use the national file as a sampling frame for carefully controlled large-scale research projects of their own. All these activities are possible, subject to the rigid safeguards we maintain of the confidentiality of data. Only anonymous or summary data are released unless written permission is received from the appropriate source authorizing the release of information on specific students or schools.

I believe that is a sufficient introduction to the work of the O.D.S. The direction of my proposal should now also be clear. As we have heard from the reports of Mr. Goulder and

Figure 1. Monthly index of births, hearing impaired students born between 1960 and 1970.



¹ Ratio of actual number of births in a given month to the average number of births per month.

Figure 2. Parental deafness and nonverbal IQ of deaf child

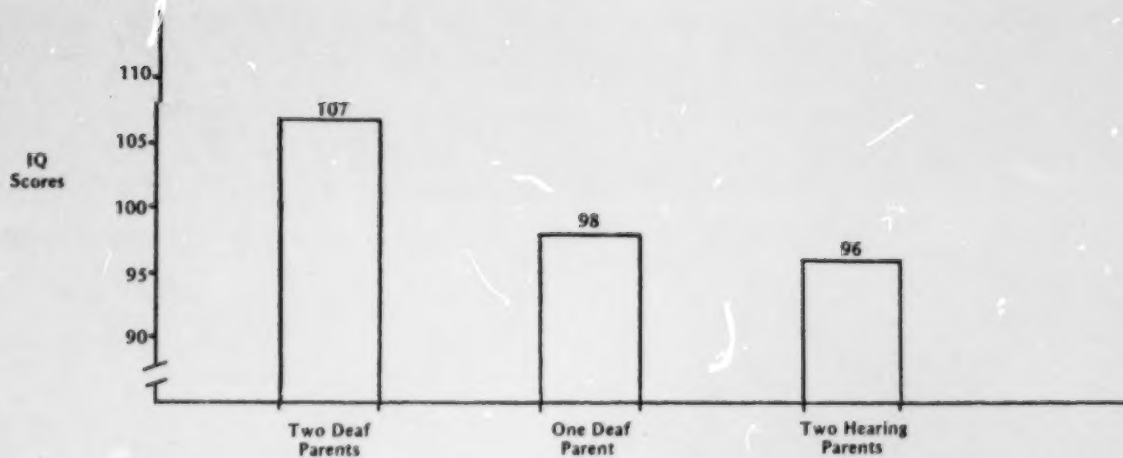
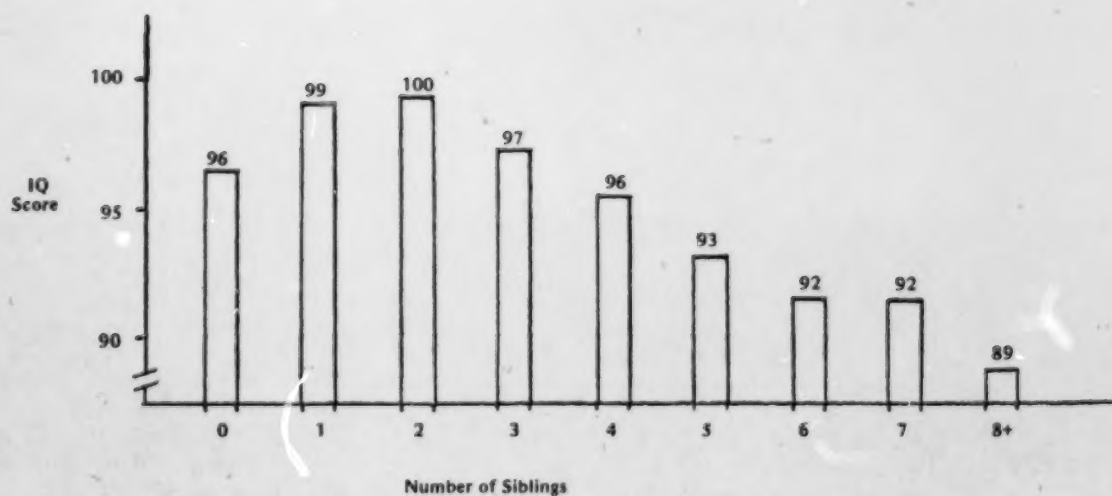


Figure 3. Number of siblings and nonverbal IQ of deaf child



Ms. Edelstein, there are now in existence perhaps 34 programs in schools, hospitals, and clinics, serving a total of a little more than 1,000 deaf persons with psychiatric problems. Few, if any, of these programs have available the staff and equipment to do extensive data collection, analysis, and research. None has a client population large enough and diverse enough to represent fairly the total national picture of services needed by and provided to deaf persons. What is needed, I submit, is a national data collection and analysis system for these mental health programs, analogous to the program I just described, which the O.D.S. operates for the special educational programs. The items of data collected would, of course, be different for the mental health programs. Items of interest here include presentation of symptoms, initial and final diagnoses, amounts and kinds of treatments received, results of psychiatric and psychological evaluations and social histories and ratings of ward behavior and behavior in the at-home or halfway house or regular school setting during trial visits or after discharge. With large scale data on items such as these, we can study similarities and differences in the symptoms and behavior observed in different centers, differences and similarities in treatments provided, and differences and similarities in the results of specified treatments for deaf persons with particular kinds of problems.

With a large data base of this sort it might become possible to conduct some national norming procedures for some of the psychological tests and other diagnostic and evaluative techniques which are widely used — as was the case with the Stanford Achievement Test in the special education setting, as I described above. Programs which wished to do so could compare their clients, their treatments, staff and facilities, their daily cost rates, and their treatment outcomes with national figures, or with figures for another specific program which agreed to share information. Depending on the level of sophistication of the system desired by the cooperating mental health programs, it could become possible to do most recordkeeping, testing, client followup evaluation, and similar procedures via the system. Then, for example, if a new ward behavior rating and a new mental status exam were performed for a given client and entered into the system, a report could be generated showing that person's first scores at admission on each measure, the most recent previous scores, the average of all previous scores, and the current results all together, thus permit-

ting a multifaceted evaluation of his current status and progress in treatment. Comparisons with national norms for similar kinds of patients could also be provided once the data base was large enough.

The potentials of this sort of system for improved patient care as well as for national research and recordkeeping are, I think, obvious. All such systems, of course, can produce output reports only as good as the input data. Therefore, such a system could never be imposed, but could come into being only as the result of deliberate, thoughtful collaboration among service programs and the agency in charge of the data handling system. If you are interested and will support the planning of a system of this sort, the Office of Demographic Studies is willing to plan with you for what could be a major resource both to support and to justify not only the continued operation of existing programs, but the expansion of services to reach that great majority of deaf people who do not presently have access to mental health services on a par with other citizens of this Nation. Perhaps some discussion and questions at this point could clarify both my proposal and your response to it.

Question: Can we receive future publications from your office as well as copies of past ones?

Response: Yes, simply write to us requesting the materials you wish — there is no charge for single copies. But remember that all the published materials will be limited to educationally oriented information, because that is the only system we have in operation right now. Educational personnel have learned over the years that this system requires a lot of work on their part, in supplying the various items of information to us, but they have also found that the results can be of immediate, practical use to them, and so we receive over 80 percent cooperation.

Question: Isn't head-count data rather limited in its usefulness?

Response: Yes, it certainly is, and that is why I am not proposing simply a head-count system, but a much broader, more flexible one. This proposal is very much like the Missouri Standard System of Psychiatry which has been operating for a number of years in the State of Missouri. All the State hospitals and mental health clinics there are linked by a computerized system into which are put nearly all records maintained in the State, including medical and psychiatric examination results, psychological test results, ward behavior ratings, ratings obtained from the patient's family after discharge, and self-ratings

from the patient himself, and a variety of other similar data. Also included are records on the nature and quantity of all treatments provided to the patient, including hours of therapy, quantities of drugs, work assignments, behavioral treatment programs, and the like. Included also are data on the costs of these various treatments as well as daily maintenance costs. From this massive data base emerge a wide range of documents for clinical records and case management purposes, statewide norms on various tests and assessments, comparisons from program to program of types of clientele served, types and amounts of treatments provided, relative efficacy of various treatments at various programs with specified kinds of persons, relative costs of all the above, and so on. Their motivation was to provide better service while "holding the lid" on costs; this they were able to do both by providing much more and better information to

program administrators, State legislators, and others, and by providing more systematic and useful client management information to the clinician with smaller investments of professional time in data collection and report generation.

Briefly, then a system of this sort can and should go well beyond head-count data to a wide variety of truly significant data for case management, program administration and budgeting, and research and development.

Goulder: From your responses to this presentation, your questions, and your show of hands here, it is clear that this conference unanimously supports this proposal and challenges its own participants, the Office of Demographic Studies, and the funding arms of NIMH to put it into operation.

Part VI
RESULTS OF THE GROUP
DISCUSSIONS

SUMMARY OF GROUP DISCUSSIONS AND RECOMMENDATIONS

Raymond J. Trybus, Ph.D.

A significant portion of the 2 days of the Orthopsychiatric Workshop on Deafness was devoted to discussions among the participants, who were grouped according to H.E.W. regions from which they came, for this purpose. The notes of the first day's discussions were typed and copied the first night, so that during the second day's discussions all participants had the benefit of at least seeing the notes of the other groups in which they did not participate. This procedure also had the effect of blurring any distinctions there may have been among the concerns of the various regional personnel, and the actual recommendations of the groups were very much in accord with each other.

Because of this extensive overlap in the discussions and recommendations of the groups, there was no need to identify specific items or suggestions as to origin. The flavor of the discussions and the resulting recommendations was often piquant, and, to preserve that flavor, the highlights of the discussion and the major recommendations are presented here as much as possible in the original words of the speakers or the group note-takers.

The very special thanks of the editor and of the conference participants are due to the four discussion group note-takers for a demanding job well done: Ms. Marlene McAleer, Mr. Steven Sine, Mr. Ed Kilcullen, and Ms. Pam Minger.

Discussion Highlights

The problems deaf people have are no different, but the contributing factors are; and parents often do not understand these differences. The moment of the diagnosis of deafness is the most important time for delivery of preventive mental health services, with parent information and counseling to deal with their lack of knowledge and their emotional reactions to the catastrophic news of the child's deafness. An extra problem in the regard is that diagnosis often doesn't occur early enough, and some critical develop-

mental stages have come and gone before the problem is recognized.

- Mental health workers of all kinds are not necessarily qualified to deal with the problems of deaf children and the family reactions to the deafness. Mental health workers still have a big stigma attached, so maybe we need some new kinds of people who are more generally acceptable, but, on the other hand, we critically need trained people and not just unskilled though willing volunteers.

- The job market, interpersonal relationships, and living problems of deaf people are important to keep in mind. Many of the psychological problems of deaf people stem from the reactions of hearing people.

- Inservice training programs of various kinds are needed, but training funds are being pared to practically nothing. And it's the administrators who get to go to conferences, not the teachers.

- Program planning in this area MUST include members of the deaf community!

- The figures say to expect 10 percent, maybe 20 percent of the kids in a classroom to have emotional problems, but mental health people can't get in until someone becomes a threat to the class or the teacher. Then there's a crisis, the mental health people are called in, the school wants the kid straightened out fast or just plain out fast. Mental health types talk about prevention, about parent education, and all that, but school administrations will only talk about individuals with crisis needs. The schools just won't refer kids early enough.

- Who will be able to serve the birth to 3-year-old group? Many States have education legislation which only allows services down to age 3.

- We need to educate the professionals, especially the physicians and the speech and audiology people, to identify not only the hearing loss as early as possible, but also to identify and steer parents to the counseling and other services which might make a real difference right

from the beginning. At the same time we need a lot of good P.R., like the cancer ads you always see on television.

- Mostly we need new programs, not new agencies. We should work with the existing agencies to set up special programs for deaf people, then maybe we will need a few special projects like halfway houses for delinquent or runaway deaf kids.

- Be persistent! The departments of vocational rehabilitation (VR), the community mental health programs *can* help — it is *not* impossible to get them together. The agencies are responsible! All the States have these resources; we just have to learn how to get them to serve our deaf people. But not all the States are helpful. Consumer support is a lot of work, but it pays off — speak loud, get people to write letters!!

- We need to introduce many more deaf people as professionals in this area and as paraprofessionals, too.

- We serve all the people who are actually in our center, but mental health services for children must involve families, and there is now no way of funding services to families. There are many such gaps in services to children. NIMH has not taken responsibility for services to the deaf. Education sees its business as training educators, not therapists. The VR people see their responsibilities elsewhere also. We need the kind of flexibility in funding that would let us put money and services where the needs are, regardless of whose lines we cross.

- Some new data as well as clinical lore are suggesting that it is school-disruptive behaviors which start the problem in a large proportion of cases. Isolation may be the number one symptom of emotional problems, but it is the disruptive behavior which the schools notice. The communication problem complicates the emotional development of the deaf child, and we need to pinpoint the problem behaviors that should be noticed and attended to as early as possible.

- There is a great need for programs of various types at all levels of disturbance and all ages. Protective, inpatient environments probably need to be on a regional basis if they are ever actually to happen, but there also needs to be a coalition between the hospital-based professionals and the school and home environments with the problems seen there. One problem is that a region may have to be quite large in order to include enough deaf people to justify a program—but then you have the problem of taking people out of their home and school environ-

ments, interrupting normal communication and family interaction. Explicit attention needs to be given to transitional programs and services to ease people back into the community after receiving inpatient service.

- The primary agents who deal with children around the time of diagnosis—the pediatricians, the speech and hearing people, and the preschool people—don't know enough about deafness or the related emotional problems or what to do or where to go. Really qualified people may not be available or may not be known to these various practitioners so that appropriate referrals often don't happen. There are real problems in this area with respect to psychological evaluation and testing when a deaf child is disturbed.

- The people in the schools for the deaf often seem defensive and unreceptive to mental health personnel; they're used to running their own shop and don't like the intrusion of outside professionals.

- How often have you heard, "Well, no, I don't sign or anything, but he knows what I am saying"? These kids are conditioned to respond favorably because of their fear of the parents who can't understand them. Is it any wonder they have problems with emotional development? We find that hearing parents usually don't cooperate with therapy. Two or three sessions, two or three sign language classes, and that's all we see of them.

- I'd like to see some real research results on all of this. I wonder if the kids aren't especially picked for these studies we hear about.

- Teachers usually are not prepared to recognize the real problem children. Teachers should be involved in behavior therapy, in other forms of therapy. At the same time, we have to be careful of asking teachers to become over-involved. Teachers can't be experts in everything.

- For the profoundly deaf, since this new legislation, the mainstreaming concept is preventing quality services. It is more and more difficult to get the money needed to provide special services. I guess no one is supposed to be special. There is money for education, but not for diagnosis and treatment.

- The lack of coordination among the schools and programs for the deaf, the training institutions, and the bureaus of the Office of Education creates the present situation with inadequate manpower being hired in the schools. The jobs require people to be social workers, speech therapists, psychologists, etc. all rolled up into one, but they don't have the necessary

skills in any one of those areas. Coordination of services is one of the important issues.

- The crux of the matter is that we need line items in the Federal budget for services to the deaf. Otherwise people unfamiliar with deafness think that all we need is to give someone a little sign language and then the services will be there without any extra funding or personnel. Programs for the deaf are funded for 3 years as long as they are considered innovative, then the funding stops and the agency has to scramble from one political level to another, competing for funds with the other handicaps and trying to establish whole new sets of working relationships. We need line items in the budget, we need continuing funds for the support of continuing programs. Serving deaf people is costly—it takes more time, more people, more money. The deaf community has to learn to play the funding game, and serve as its own advocate. The consumers are the real players who are listened to, not the professionals who can be easily seen as self-serving when they advocate more programs, people, and services.

Major Recommendations

- Line items in the Federal, State, and local budgets for services to the deaf.
- Schools need trained professionals and consultants to do adequate psycho-educational evaluations in the schools. But regional referral centers are also necessary for the more severe and complex cases.
- A channel of communication to share ideas, trends, descriptions of programs, problems and solutions that worked or failed. Some kind of journal or newsletter.
- Specialized training for trained mental health workers to introduce them to the problems of deafness, and stipends which will spur the interest of such professionals in taking this additional specialized training.

- Massive public information campaigns to the medical profession, the speech and hearing people, and the public at large.

- Continuing inservice training opportunities for mental health workers with deaf people.

- Get schools to inform their students that they have a right to mental health services.

- Develop a statement of national priorities in this area, including:

- (1) educating educators on specific mental health needs of deaf children and the available programs to serve them
- (2) exploring the potential for comprehensive State planning for services
- (3) exploring additional funding avenues as Federal funds continue to wane.

- Start one training program for mental health workers with the deaf at some appropriate location.

- National workshops and lectures don't get down to the real questions of the direct service providers. There should be regional or local followup workshops — perhaps the universities would be willing to help arrange these. Timing is important, since someone has to "mind the shop."

- NIMH needs a special unit or office to concentrate on mental health services for deaf people.

- The present workers need inservice training, not only on the deafness side, but on the theory and techniques of diagnosis and therapy on the clinical side. There is a great need for "brass tacks" information.

- We need meetings where the Federal types have to sit and listen to the needs and problems of the front-lines people, instead of lecturing. Our meetings are too stratified: the bigwigs talk to each other and the decisionmakers never hear the real concerns of us "little guys."

- We need to keep the professionals together where they can do some good. The decentralization idea will just never work in this field — there will never be enough specialists to be spread around everywhere.

Part VII
SUMMARY,
RECOMMENDATIONS,
CHALLENGE, AND
RESPONSES

CONFERENCE SUMMARY AND RECOMMENDATIONS: THE CHALLENGE

Thomas J. Goulder, Ph.D., and Terry J. Edelstein

I would like to summarize this conference by making the following recommendations and posing them as a challenge to our Federal representatives. Therefore, I propose:

First, that each State that presently has mental health services in education or in mental health centers establish a working committee to foster and promote mental health services in that State and to work in cooperation with the ongoing mental health services.

Second, that the regions meet together on an annual basis and plan specific services for the region.

Third, that a national training program or center be established to train mental health professionals and paraprofessionals at all levels.

Fourth, that a model children's program be established to serve deaf children who are emotionally disturbed to assist parents in dealing with this problem.

Fifth, that a model program be established somewhere in the United States to serve the in-

dividuals with behavior and personality disorders, who are so frequently being referred to the existing mental health programs, which are ill equipped to serve them.

Sixth, as Dr. Trybus has suggested, I propose that we establish a coordinated system of data collection and dissemination for both the educational and the mental health fields.

Seventh and finally, as Dr. Sussman has illustrated for us, I propose that across the United States we establish some models of community mental health services for deaf people.

I am happy that this conference has seen a joining of forces between the school programs for emotionally disturbed deaf children and the hospital- and clinic-based mental health programs for deaf people. I think that is important because we are working with the same population and there needs to be some transfer from one place to another, with both sides working together. I think we have started a movement in that direction today.

RESPONSE TO THE CHALLENGE FROM THE NATIONAL INSTITUTE OF MENTAL HEALTH

Luther D. Robinson, M.D.

I think that you have given me a big challenge, and I don't know if I am tall enough to meet it. I see this little platform here adds a bit, so I'll try to do my best. First of all, I want to commend Dr. Goulder and Ms. Edelstein for putting this workshop together. I think that I have learned as much, if not more, in this workshop as I have in my whole 13 years in the business.

The fact that Saint Elizabeths Hospital is a division of the National Institute of Mental Health in itself gives some indication of NIMH's commitment to improving mental health services for deaf people. We have five divisions of NIMH represented here in this workshop — I might say six, including Saint Elizabeths — those divisions include the Division of Biometry and Epidemiology, the Division of Manpower and Training, the Division of Extramural Research, the Division of Mental Health Services, and the Office of Children and Youth. Now most of these divisions give help through funding and technical assistance and, of course, States and local communities submit grant proposals or applications for projects. The review process for these proposals is very complicated, and even some of the branch and division directors of NIMH, who may be advocates for these projects, cannot or do not have the authority to approve them. So it is quite complicated. I must say too, unfortunately, that many of the divisions of NIMH have really not been aware of deafness, to say nothing of the mental health problems of deaf people. So this has been an eye-opener for the division directors of NIMH.

Among all the divisions of NIMH, I suppose that Saint Elizabeths Hospital has been the main division which has been involved in mental health services to deaf people. And, in our own humble way we have tried to meet some of these challenges, and I believe we are still in the position to do more. In the area of services, being a national facility, we have provided direct services in the form of patient care and treatment to

about 26 States and the District of Columbia, and have covered some 150 patients during our 13 years of existence.

In the area of training, we have assisted first by giving training in mental health services for deaf people to those stipended trainees who are already here at Saint Elizabeths to receive approved training in their specific disciplines. These have included psychiatry, clinical psychology, social work, nursing, clinical pastoral care, psychodrama, art therapy, dance therapy, occupational therapy, recreational therapy, and perhaps a few more. Now these trainees only spend a small portion of their whole training time in the Mental Health Program for the Deaf.

In addition we have been able to provide special programs for colleges and universities, to help in the satisfaction of curriculum requirements for their students, and accordingly, we have set up training programs for mental health counselors, general counselors, those in clinical pastoral care, art therapy, and social work, and are in a position to develop other programs on an as-needed basis. The problem here, though, is that there is no Federal funding, no stipends for these programs. Whatever stipend these trainees get comes from their own universities or from their own private resources.

One of your challenges was that of getting a Federal stipend for training workers for mental health services for deaf people. I can only say that such a proposal could be made to the National Institute of Mental Health, and I am sure that it would be given very strong consideration. I don't know of an existing authority at this time, but I'm sure that when needs are made known, efforts can be made to meet those needs, or at least to investigate the possibilities of meeting those needs.

There was also a suggestion that the National Institute of Mental Health should have a position, a person, representing mental health services for deaf people. I must say that in a very

modest sense, NIMH does have such a person, and you are looking at him now. But perhaps much more visibility could be given, maybe if there were a division within NIMH, for providing mental health services, or rather a division of mental health programs. I am sure that that is a lot easier said than done. Determinations have to be made for national needs, and of course you know how those things come about.

On the matter of research: recently I made a survey, or rather I gathered printouts of all the research proposals which have been approved and funded by the Alcohol, Drug Abuse, and Mental Health Administration, primarily by NIMH, over the past 10 years, and they amounted to some 24. Nine of these, I believe, are still in effect or were in effect up into 1975. The proposal which Dr. Trybus made, about a national data system for mental health for the deaf — I'm sure that the Division of Biometry and Epidemiology of NIMH would be very receptive to such an idea and would be willing to provide any kind of support and assistance which they can, and surely this will come to the attention of the director of that division.

Someone in one of the groups made a recommendation for dissemination of information. I

will say here that just in the past month, Saint Elizabeths has received authority from its hierarchy to publish a journal or bulletin which indeed could serve that purpose. We welcome input from all the program directors, and from people involved in providing mental health services to the deaf from around the country, so that we may include this in issues of our publication which will be circulated regularly, at least quarterly, we hope.

Someone touched upon prevention. Now prevention is a very important part of dealing with mental health problems of deaf people and I'm sure that the National Institute of Mental Health could provide expertise or give some support to educational programs, at least programs in public education, which could serve in a preventive role in the development of mental health problems.

I don't know if I have answered all the challenges, but I would like to just close by saying again that I think the fact that the National Institute of Mental Health is so visibly represented here in this workshop gives an indication of at least some beginning efforts on the part of NIMH to meet the challenges which you have presented.

RESPONSE TO THE CHALLENGE FROM THE REHABILITATION SERVICES ADMINISTRATION

Boyce Williams, LL.D.

I know it is a mistake to start with an apology, but I feel compelled to do that. I am very sorry that I have missed so much of this meeting.

The subject of mental health has always been very close to us in vocational rehabilitation. The problem is very simple but insoluble. We have only two people, but had four meetings today for us to attend before this, the fifth one. They were not my meetings or they would have been cancelled, in deference to this one.

I think one of the most exciting observations I have heard these past few years was Dr. Robinson's remark that, "At long last the sleeping giant is stirring, starting to wake up and realize that there really are deaf people who do have mental health problems and that it is time to do something about them." It was not like that 20 years ago. I can remember very clearly a meeting at NIMH when we discussed the beginning, pioneering work at the New York State Psychiatric Institute. We had a wonderful audience, Dr. Felix, who was the chief for many years. We thought it was beautiful, wonderful, and we said, "Come on, let's get together on this. Let's work together." "Oh no, you do it. It's your game." NIMH was not interested in getting involved at that time. Now we have reached the point where the leadership is here, as it should be, and we can expect that all over the country there will be really effective programs meeting the needs of emotionally disturbed deaf people.

I have made a very few notes here of things I am personally aware of as very basic needs. A strange characteristic of the deaf population is that it is not effective competitively except within its own circles where deaf people talk to each other. Deaf people do *not* procure a fair share of the public service programs. In my own program, where we have professional training, research, evaluation, and service delivery, the record is not one we can brag about. Despite the fact that we have people in the central office

here in Washington and specialists all over the country, we are still in the dark on level of performance. Meetings like this one will help us produce leverage to improve that situation, or we hope so anyway. With your help it will happen.

Perhaps the most useful thing that could happen would be that we would start being successful in getting hard money into our programs. That relates to the relatively poor competitive circumstances of deaf people socially. By hard money we mean earmarked funds in the Federal budget and subsequently in the State service delivery levels which depend on grants-in-aid from the Federal Government. The first thing I think we should strive to accomplish — I don't know if it needs to be the first thing, but it is one of the important things we must accomplish — is hard money in mental health, in vocational training, in all kinds of public services, so that our deaf population gets a fair break.

I'm going to try to relate that to the vocational rehabilitation program. We do have a framework that can be used and should be. That is a framework of people, hard working people; we have about 20,000 professional people in the State-Federal vocational rehabilitation programs. During the past several years since the establishment of the model State plan for vocational rehabilitation of deaf people, almost all States have now appointed what we call State Coordinators for the Deaf (SCD's) in vocational rehabilitation. These are key people; they have the ear of the State V.R. directors. They can contact leading people, executives, administrators, and program leaders in other State service programs: employment, health, welfare. The SCD's can and should be fully involved in the development of this important challenge of appropriate mental health services for deaf people.

Supplementing the SCD's we have several hundred rehabilitation counselors for the deaf

(RCD's). They are the experts who carry almost entirely the caseloads of deaf people, a substantial number of whom have emotional or mental health problems. They are important allies in your work in developing action back home. On any given day of the year, our program in all of the States has in service status some 20,000 to 22,000 deaf clients. That's a large number. We turn out or rehabilitate annually about 7,000 — but don't ask me any more about that because our reporting system has been computerized to death, and I can't find out anything any more at all except the round numbers. Everything is in the computer now and the answers are not there like they were when we had paper reports.

In my remarks yesterday on the panel here I made some strong statements, and I'd be happy to make them again, but, following me, one of my colleagues on the panel described the circumstances of revenue sharing, relating to decentralization. Do you recollect that? I was anxious to get the floor again, but I couldn't,

so here I am now. Revenue sharing is a principle, it's a fact, but the Federal Government has a responsibility in revenue sharing to see that appropriate guidelines go with it. Otherwise that money goes out without protecting the rights of the individual, and there's something wrong in that. And I will stand on that. I've seen too much of that happen: things like mainstreaming in education without any real understanding of what is involved. Can any of you who are really deeply knowledgeable about deafness and deaf people not see the mental health problems that fester out of that kind of action?

We can do better, and we will do better with the leadership and help of people like Luther Robinson and Tom Goulder and Terry Edelstein. We will make much more rapid progress than we ever have in the past. I really have enjoyed being here for the short time that I have been, and I hope we can do it again, and again, and again.

RESPONSE TO THE CHALLENGE FROM THE BUREAU OF EDUCATION FOR THE HANDICAPPED

Herma Saettler, Ph.D.

Dr. Saettler is head of the Division of Personnel Preparation of the Bureau of Education for the Handicapped, U.S. Office of Education.

It's been a number of years since I have had the opportunity to address a joint group in terms of mental health and deafness. Back some 18 years ago when I was working in the mental health system in the State of Illinois, we had a number of children in the hospital in which I was working in the education field, who had severe hearing problems and deafness. At that time we were extremely confused and did not really know what to do in terms of services for these children; yet we all knew, both in education and in mental health, that services were needed. At that time the State began to develop some exploratory development of services. However, over time, as interest dropped, the programs dropped at the same time.

I think we're beginning to see now a resurgence and a renewed effort to provide service to all the people in our programs, including the most severely involved children. It seems that, unfortunately, the most severely involved children and adults are the ones whom we seem to get to last of all, and yet who need the services the most. It is to this effort that we see this particular meeting over the past two days has been directing its efforts.

There were a number of very interesting and, I think, important comments made by the summaries of the regional discussions, which I would like to comment on, and also some of the challenges which have been presented here. One interesting point came from the Regions I and II discussions, and that dealt with more services that are needed, more satellite services, 24-hour walk-in services, family therapy, marriage coun-

seling, and work with the normal hearing child within a family where there may be a deaf child. In terms of service delivery within this area, there are basically two choices at this point: institutionalization in a huge mental institution or no services whatsoever unless a family can afford private psychiatric services. We need a full range of services available to the deaf population, including the families of deaf adults or families in which there are deaf children. It is important to have this full range of services available.

Another observation dealt with a crash program in terms of manpower training. This, I think, relates to a later observation that dealt with a major effort of giving additional skills to those who are already working in the field, to begin working with some of the mental health problems. The retraining of classroom teachers, retraining of mental health aides to begin working with deaf children who have mental health problems, is what is needed.

There was another observation in terms of the need for more money for services to deaf people who are not sick enough for hospitals. At this point, for most deaf individuals, there are not many mental health services available. By developing a fuller range of services, we can better meet the needs of all individuals. What's interesting is a policy by some of our service agencies that one could view as discriminatory, that is, that some service agencies dealing with the handicapped specifically exclude certain handicaps. This was true, I know, in the service program I worked with in the State of Illinois.

We felt that because we did not have the knowledge base and did not have the skills to work with children who were deaf, another facility was more appropriate. But at that time we could not refer anyone to another service; no one else was dealing with the problems and needs of these children. It seems today, when we are much more fully developed in terms of programs, we have the greater knowledge base of working with children and adults who have mental health problems, but we still exclude from our programs those individuals who have these particular problems.

One of the other observations dealt with the issue of specific line items of funding for particular programs dealing with deaf people. Congress has clearly identified and indicated to the Bureau of Education for the Handicapped for priority in funding two areas: one is the unserved child, and certainly the children we have been talking about in the past 2 days are some of the most unserved children in terms of their needs; the second priority which the Bureau has charged to it by the Congress deals with the most severely involved child within each area of handicap. Again, this is the type of child we have been talking about.

The effort in terms of securing hard funding, I think, is very critical. For many programs at the Federal level, the funding is on a year-to-year basis. Applications come in on a year-to-year basis and are in competition with everyone else for funding. We must begin to secure — and I see it coming — greater hard money, line-item positions in local and State budgets to continue funding these efforts. In some Federal programs, as is true in ours, funding is viewed as catalytic, developing the models with the basic understanding and assumption that State and local funds will eventually assume the major costs of those programs. But that only happens if, at the local level, there is actual assumption of that cost, and inclusion in local budgets.

There was another observation in terms of breaking some of the barriers between agencies. In trying to set up a comprehensive service at the local level, we might have to go to 10 or 15 different sources of funding to carry forward that effort. There are some models at a Federal

level in which there have been, over the past 8 years, exploratory efforts at comprehensive services which you might want to look at. One of these is under the developmental disabilities university affiliated facilities programs, which develop comprehensive services in relation to the mentally retarded and developmentally disabled. It is a model you might want to look at carefully.

For the development of a national training center, here I would look at a need to identify a number of programs that would begin focusing on training people in education to deal with these problems in the classroom. There are possibilities of developing early childhood model service centers already, within existing legislation.

One of the other key things that was mentioned earlier under the observations of Regions I and II could also have wide impact for us. That is the need to have deaf persons as mental health aides. We need to begin encouraging activity along two lines. For one, more of our students who are deaf need to have a wider concept of various careers and vocational opportunities open to them, and need to move into some of the training programs that currently exist for training people in mental health care services. At the same time these programs should be actively recruiting handicapped individuals. In fact, under sections 503 and 504 of the Rehabilitation Act of 1973, these individuals who are handicapped cannot be discriminated against on the basis of their handicap.

I think as we begin opening up more regular training programs, not only in education but in mental health, to individuals who are handicapped, then we will begin to understand a little more the problems that they are facing. As we begin to see our problems, we see that there is very little difference; that among all of us, there are many more similarities than there are differences. As we begin to open up new avenues of endeavor for persons who are both deaf and who have emotional problems, their benefit is also our benefit, and we can only grow as they grow. It is our job to assist in whatever way we can as individuals, as "bureaucrats," but as human beings in working with other persons.

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